

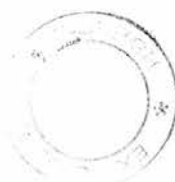
**Perplexed parenting: fathers' experiences of having a son
who has attention deficit hyperactivity disorder.**

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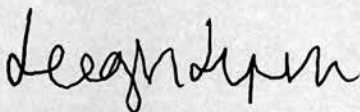
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DECLARATION

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

A handwritten signature in black ink, appearing to read 'Leigh Anne Lynch', written in a cursive style.

Leigh Anne Lynch

15 August 2008

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ABSTRACT

Background: Attention deficit hyperactivity disorder is one of the most commonly diagnosed and intensively researched behavioural disorders in the world (Tannock, 1998). ADHD not only has an effect on the individual child, but also has an impact on parents. Having a child with ADHD is associated with disturbances to family and marital functioning, disrupted parent-child relationships, reduced parenting efficacy, and increased levels of parent stress (Johnston & Mash, 2001). However, there is a dearth of qualitative studies that investigate the experience of having a child with ADHD from the perspective of the parent. In the few qualitative studies that have been carried out, fathers are often not included, or are not differentiated in terms of their experience of being a parent. The aim of this study is to explore the particular experience of what it is like to be a father of a son with ADHD, from the first awareness of difficulties with their child to the present day.

Method: Eight fathers of boys with ADHD participated in interviews. All interviews were transcribed verbatim and analysed using Interpretive Phenomenological Analysis (Smith, 1996).

Results: the following six superordinate themes emerged from the analysis: ‘the search for answers’; ‘working with the diagnosis’; ‘perplexed parenting – parenting a son who has ADHD’; ‘the battle to balance family life’; ‘heightened sense of parenting responsibility’ and ‘managing uncomfortable emotions’.

Discussion: only one father instigated the diagnosis, the other fathers’ were not at the same stage as mothers’ in accepting that a medical investigation was warranted, which had implications for fathers’ adjustment to the diagnosis. Other implications include father’s attributions toward the diagnosis and their son’s behaviour. Parenting was a perplexing process and fathers typically described having difficulty adapting to the diagnosis. However, fathers demonstrated fighting hard to adjust to their child’s diagnosis and manage the family system within the context of the condition. Fathers reported being highly protective of their sons and were proactive in making positive changes for their child. Fathers managed their emotions through a number of strategies. It is recommended that services involved in the diagnosis and management

of ADHD in children be mindful of the differing perspectives of mothers and fathers and seek to involve both parents to allow a smooth adjustment to the diagnosis for the family system. It is also recommended that services make available follow up behavioural training and parenting interventions for fathers. Suggestions for future research include following up fathers who normalise their sons behaviour pre-diagnosis to ascertain their psychological adjustment to diagnosis.

1. Introduction

1.1. Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is the diagnostic label used to describe children who have developmentally inappropriate levels of inattention, hyperactivity and impulsivity¹ (Barkley, 2006). It is one of the most commonly diagnosed and intensively researched behavioural disorders in the world (Tannock, 1998). ADHD can persist into adulthood with as many as 60 per cent of people having continuing difficulties (Weiss *et al.*, 1999). It is pervasive in nature and can have a significant impact on the person's academic, social and emotional adjustment (Chronis *et al.*, 2006).

The core deficits of impulsivity, hyperactivity and inattention can lead to a number of secondary deficits. Impulsivity and aggression can lead to difficulties in making or maintaining appropriate peer relationships (Snyder *et al.*, 2004). The core deficits cause difficulties for parents and, compared with normal controls, parent-child relationships with children who have ADHD are characterised by less compliance from the child, more conflict and more directive, controlling and authoritarian parenting (Johnston & Mash, 2001). Problems with self-esteem and depression can develop as the child becomes aware of repeated failures in home, school and social situations (Barkley, 2006) indeed ADHD commonly coexists with mood disorders (SIGN, 2001).

As the child develops into adolescence, impulsivity is linked to risk taking behaviour an increased risk for developing substance use problems (Molina *et al.*, 2007) and

¹ The DSM-V-TR (APA, 2000) criteria for diagnosis is in appendix I

serious conduct problems (Loeber *et al.*, 2000) and often co-exists with conduct disorder (SIGN, 2001). The most common types of conduct problems include theft, aggression to people or animals, violation of rules such as truancy or running away from home (Barkley, 2006). ADHD commonly coexists with other disorders, such as oppositional defiant disorder. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association [APA], 1994), oppositional defiant disorder is characterised by anger, losing one's temper, often arguing with adults, and actively defying or refusing to comply with adult's requests or rules.

1.1.1 The ADHD Debate – Diagnosis

The first scientific descriptions of ADHD were presented in 1902 (Still, 1902) yet ADHD has remained one of the world's most controversial disorders. The debate over whether or not the condition exists as a distinct entity is out with the scope of this study; however, the most salient points related to this study will be highlighted.

The definition, aetiology and theoretical basis of ADHD has varied in the past 30 years and there is no medical test that can identify the disorder (Timimi, 2004). This has led to confusion and uncertainty about whether ADHD is a distinct disorder and diagnosis can be controversial. For example, the symptoms that are seen in ADHD can be attributed to behaviour that falls within the domain of normal child development, such as a child misbehaving or being boisterous (Timimi, 2004). From a cultural perspective it is argued that changes in cultural expectations of children in addition to pharmaceutical companies promoting the concept of behaviour out with the norm as being abnormal and needing an intervention as the problem, not the child, Timimi (2004) argues:

...the current "epidemic" of ADHD in the West can be understood as a symptom of a profound change in our cultural expectations of children coupled with an unwitting alliance between drug companies and some doctors, that serves to culturally legitimize the practice of dispensing performance enhancing substances in a crude attempt to quell our current anxieties about children's (particularly boys) development. (pp. 61).

However, according to Barkley (2006) multiple aetiologies may lead to ADHD, and that genetic and neurological factors are “the greatest contributors to this disorder” (pp. 219). According to Barkley (2006):

Evidence continues to mount that ADHD is associated, at least in part, with structural and/or functional differences from normal in the frontal lobes, basal ganglia, and cerebellum, and possibly the anterior cingulate (p. 220)

In an attempt to resolve the academic dissonance regarding ADHD, a group of over 80 leading researchers in ADHD produced an International Consensus Statement on ADHD:

...the periodic portrayal of attention deficit hyperactivity disorder (ADHD) in media reports...inaccurate stories rendering ADHD as myth, fraud, or benign condition...the notion that ADHD does not exist is simply wrong. All of the major medical associations and government health agencies recognize ADHD as a genuine disorder because the scientific evidence indicating it is so overwhelming. (Barkley, 2002, pp 89)

1.1.2 The ADHD Debate - Medication

Once a diagnosis of ADHD is made, the decision about medicating their child is a common intervention that parents consider. Central nervous system (CNS) stimulant medications are the most commonly used medication to treat the symptoms of ADHD (Barkley, 2006). Since the 1960s over 200 controlled trials of stimulants have been completed (Barkley, 2006). Many studies have found that medication improves the core symptoms of ADHD and enhances the social, academic and behavioural functioning of the child (Barkley, 2006). However, side effects can occur, such as decreased appetite, insomnia, anxiety, irritability, and proneness to crying (Barkley, 2006) and once the medication has worn off the ADHD symptoms will reappear (Neophytou & Webber, 2005).

The only longitudinal study of stimulant medication is the National Institute of Mental Health (NIMH) major collaborative multisite randomised clinical trial for a childhood

disorder (MTA cooperative group, 1999a, 1999b). The results of the study have provided much controversial debate.

The six sites compared four treatments: medication alone, a combination of medication and behaviour modification, behavioural modification, and community comparison. The treatments were compared at the end of treatment at 14 months (MTA cooperative group, 1999a) and followed up at 24 months (ten months after treatment completion) (MTA cooperative group, 2004). The full methodology is discussed in MTA Cooperative Group, 1999a and will not be discussed here for brevity. The results showed that after 14 months all four groups improved over time but that combination and medical management were statistically superior over behaviour modification and community comparison in terms of ADHD symptoms. However, at the 24 month follow up the effect size had halved. Moreover, the MTA cooperative group also investigated side effects of the medication used in the study and found that consistent use of stimulants were associated with mild growth suppression (MTA cooperative group, 2004b).

In a recent television documentary, co-author of the MTA study, Professor William Pelham, discussed the poor efficacy for the long term use of psychostimulants highlighted in the MTA study:

In the short run [medication] will help the child behave better, in the long run it won't. And that information should be made very clear to parents...I think that we exaggerated the beneficial impact of medication in the first study. We had thought that children medicated longer would have better outcomes. That didn't happen to be the case. There's no indication that medication's better than nothing in the long run.

(Pelham, Panorama, 12/11/07)

The documentary also highlighted that general practitioners are prescribing anti-psychotic drugs for behavioural problems seen in ADHD. Dr Tim Kendall of the Royal College of Psychiatrists research group and lead for the new National Institute for Clinical Excellence (NICE) guidelines on the diagnosis and treatment of ADHD, also raised his concerns about the available treatment:

A generous understanding would be to say that doctors have reached the point where they don't know what else to offer and they haven't got the right supports to help parents and children in difficult circumstances. But I think perhaps even that is no real excuse for drugs which are associated with such severe side effects.

(Kendall, Panorama, 12/11/07)

1.2 Parenting a Child who has ADHD

Much of the ADHD research has focussed on the aetiology and medical treatment of the disorder. According to Johnston and Mash (2001) less focus has been given to the families of children who have ADHD and although families have been studied for over a quarter of a century, they state:

Recent attention to this topic has waned and its importance has, perhaps prematurely downplayed ... (pp. 183)

Indeed studying the families of children who have ADHD is important as the disorder not only affects the child, but also has an impact on the wider family system. Much of the parenting literature focuses on the mother's experience and there is an under-representation of fathers. However, in order to orientate the reader, some of the general difficulties for parents will be discussed, studies of mothers will be discussed and it will be highlighted where fathers are included in the studies.

1.2.1 Difficulties in Parenting a Child who has ADHD

As the child with ADHD develops, the disorder has differing levels of impact on their functioning and subsequently the impact it has on the people around them changes (Harpin, 2005). The primary school years will be the main focus here as this is the age range of the children in this study.

In home settings, parents report difficulties with their child complying with their instructions, often having to continually repeat instructions and prompts. This can relate to not completing chores, disorganisation and rule violations such as misbehaving. Difficulties in sibling relationships are common (Fabiano, 2007).

Children who have ADHD have poor impulse control and have difficulties thinking through the consequences of behaviour which places them at a higher risk for accidents (Cunningham, 2007) and as result a high level of supervision is needed from parents (Harpin, 2005). Related to impulse control, children with ADHD have high levels of activity whether it be motor or verbal. According to Barkley (2006) parents describe children as being:

“Always on the go” “acts as if he was driven by a motor” “climbs excessively” “can’t sit still”
“talks excessively” “often hums or makes odd noises” “is squirmy” (p. 82)

These developmentally inappropriate behaviours can be tiring for parents and can also cause difficulties for parents in social situations in managing the child’s behaviour (Harpin, 2005). Related to over activity children often have poor sleep patterns which have an impact on the parents sleep pattern as they have to supervise the child (Harpin, 2005).

The school setting can be difficult for children who have ADHD which causes increased stress for parents. Arcia *et al.* (2000) found that often teachers have little information about the nature of ADHD and how to manage the child within the ADHD context. It is often difficult for the child to manage the same level of work as other pupils. Barkley (2000) reports that in terms of organisation and social skills children with ADHD are typically 30 per cent or more behind that of the other pupils. Moreover, co-morbid learning difficulties can further hinder the child’s academic success (Harpin, 2005). Difficulties in social skills can often cause conflict, rejection and social isolation from their peers (Ladd & Troop-Gordon, 2003). Children with ADHD are vulnerable to experiencing repeated failures and difficulties at school and may refuse to go to school (Barkley, 2006). According to Barkley (2006) home-school conflicts can develop where parents feel that their child’s difficulties within school are related to the school not addressing their child’s needs; whereas teachers may believe that family problems are causing the child’s difficulties.

Additionally children with co-morbid conditions such as oppositional defiant disorder can have increased strain on their parents. Children with ADHD and oppositional defiant disorder typically display higher levels of oppositional behaviour, aggression

and higher levels of impulsive behaviour (Barkley, 2006). In a study of these two disorders, Edwards *et al.* (2001) found that mothers, fathers and children rated themselves as having more issues regarding conflict, more anger during ‘conflict discussions’ and more negative communication in general than the control group. The study also found that the co-morbid group used more negative communication and aggressive conflict tactics. This study, like the majority of research on ADHD and family functioning was based on cross-sectional designs comparing family relationships in families with children who have ADHD and those without. However, these designs do not permit an understanding of the causal mechanisms linked to ADHD and parent-child interactions and family relationships (Cunningham, 2007).

1.2.2 Parenting Stress

Numerous studies of parent-child interactions with children who have ADHD have been carried out using observational studies (Cunningham, 2007) and as discussed earlier they have consistently shown that both parents display higher levels of negative and controlling behaviour (Johnston & Mash, 2001). It is also recognised that the relationship between behaviour problems and hostile parenting is bidirectional - that is, children’s behaviour has an effect on parents and parent’s reaction has an effect on child’s subsequent behaviour (Collins *et al.*, 2000). Indeed the difficulties in the parent-child interaction are often linked to parenting stress in comparison to comparison parents (Johnston & Mash, 2001). In an early study of parenting stress and ADHD, Baker (1994) compared mothers and fathers reports of stress and found that mothers reported more stress than fathers; however, this was not a significant difference. This research suggests that both mothers and fathers experience similar levels of parenting stress. Interestingly, in the MTA study, no treatments were found to reduce the levels of stress felt by parents (Wells *et al.*, 2000).

1.2.3 Family Systems

Systemic theorists argue that the family consists of a number of complex subunits, and that a change in one part of the system will change the balance throughout the family system (Minuchin, 1985). Therefore a child with behavioural difficulties such as ADHD will alter the stability of the system and the subsystems within it.

Buhrmester (1992) studied mother and father dyads (parent-son) and triads (both parents-son) of hyperactive sons and normal sons. They found that within the mother-son dyad there was more coercion in the sons who were hyperactive than the normal sons. This dynamic carried over to the triadic system, however, fathers then engaged in a *rescue-coercion* pattern. That is, fathers increased their demands became more aversive than they (fathers) had done in the dyadic setting, and mothers decreased their demands. Both father and son became more aversive to each other in the triadic setting than the dyadic. Indeed the changes in the system as a result of ADHD such as strained alliances between parents, parents and the child with ADHD or between siblings is a target in parenting training interventions for ADHD (e.g. Anastopoulos *et al.*, 1996; Cunningham *et al.*, 1998). Therefore in order to understand the changes within the family system as a result of ADHD and the mother-father roles that adjust to the change in the system, it is important to study those within the system. However, little is known about the father's role in adjusting to the changes within the system and the father's perspectives of this adjustment.

1.2.4 Marital Discord

Johnston and Mash (2001) surmise that studies of marital relationships and relationship satisfaction in parents of children who have ADHD have found inconsistent findings. However, according to Cunningham (2007) marital conflict is particularly associated with ADHD and oppositional problems in children. Once again, difficulties with assuming causality are present. Moreover, in structural family therapy the child's behaviour may be seen as functional in terms of diverting attention or providing a focus for family difficulties (Carpenter & Treacher, 1982).

1.2.5 Parental Attribution and ADHD

Attributional research has been investigated in parents who have children who have ADHD. According to Cunningham (2007) parents of children who have ADHD are more likely than parents of non-ADHD children to feel less control over their child's difficulties. They are also more likely to attribute their behaviour to a stable internal cause and respond to these behaviours more negatively.

However, much of the research on parental attributions has focussed on the mother-child relationship. Fathers have been included in previous research however, for most the numbers were too small to make a comparison with mothers and instead were analysed as a homogenous group as parents.

However, Chen *et al.* (2007) recently studied families of children who have ADHD and compared mother and father attributions for their children’s behaviour. The study found that both mothers and fathers reported negative reactions for behaviours that they attributed as more global (happens in many situations) and stable (will happen again in the future). However, in comparison to fathers, mothers saw ADHD behaviours of inattention and impulsiveness as more likely to occur across different situations in the future. For fathers there was a significant association between *negative* reactions for behaviours perceived as internal (believed the behaviour was within child’s control, i.e. intentional) The study also investigated mother’s and father’s beliefs about the causes of ADHD, which may explain why fathers believed that their son’s inattention and impulsive behaviour was intentional. Mothers were more likely to see ADHD as a biological disorder that is chronic and pervasive (global and stable). Fathers were more likely to endorse less evidence based beliefs, psychological causes for ADHD symptoms such as lack of effort and more likely to see the behaviour as transient. Therefore mothers did not negatively respond to behaviour as they attributed the behaviour to ADHD and not being intentional. The study highlights the differing attributions that mothers and fathers have regarding their son’s behaviour and the aetiology of ADHD.

Johnston and Ohan (2005) have proposed a basic socio-cognitive model of parents attributions in parent-child relationships (see figure below):

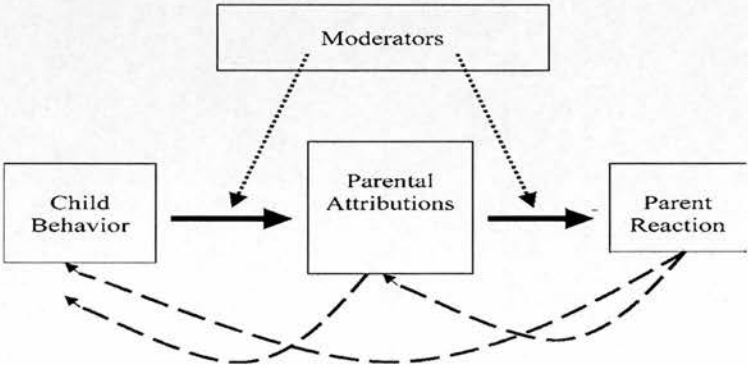


Fig. 1. A social cognitive model of parental attributions in parent-child interactions (Johnston & Ohan, 2005)

The socio-cultural model suggests that the parental attributions are the mediator or the interpretative filter that applies meaning to the child's behaviour in order to guide the reaction (see solid lines – the dashed lines represent a feedback loop that may function). Johnston and Ohan (2005) propose that when parents are faced with particular child behaviours the attributions they make for the behaviour are along the dimensions of control, locus and stability. Johnston and Ohan (2005) use the following example to illustrate this:

...when a child refuses to eat his vegetables, the parent may decide that the behaviour is caused by the child's lack of hunger (internal, uncontrollable, transient cause), or because the vegetables are soggy and cold (external locus), or because the child is stubborn and always refuses to do as he is told (internal, controllable, and stable cause). (pp.171)

The attribution that the parent makes is an important factor in the emotional response of the parent in response to child behaviour. However, Johnston and Ohan (2005) note that the model is a basic model and only partially explains how parent's attributions operate within the complexities of a parent-child interaction. In particular they note the following limitations of the model: other factors aside from the actual behaviour can influence a reaction, such as parental affective state and personality, parental beliefs and goals and the sociocultural context. In addition the attributions may not be rationally or consciously derived, they may be an automatic schema-level process (Johnston & Ohan, 2005). If this is the case, this provides challenges in researching attributions as they are less accessible to verbal report.

1.2.6 Parenting Sense of Competence

According to Cunningham (2007) in studies comparing parents with and without children who have ADHD, parent's of children who have ADHD felt a lower sense of parenting competence and they feel less confident in their parenting skills. Hoza *et al.* (2000) measured parents' cognitions about themselves, their children and their parenting before and after treatment (as part of the MTA study). They found that

mothers of children who have ADHD were more likely than fathers to report an external locus of control, lower parenting efficacy and low self esteem. In addition, poorer child outcomes were related to:

Low self esteem in mothers, low parenting efficacy in fathers, and fathers attributions of non-compliance to their child's insufficient effort and bad mood ... (pp. 569)

Parental cognition appears to be associated with particular outcome for children, and in some cases (e.g. Chen *et al.*, 2007; Hoza *et al.*, 2000) there is a difference between the mother and father.

1.3 Qualitative Investigations in Families of Children who have ADHD

The above empirical literature has highlighted that being a parent of a child who has ADHD can have particular difficulties. However, there is a paucity of qualitative investigations from the perspective of parents of children who have ADHD. Qualitative research is important in order to understand how parents are experiencing and making sense of their child's condition and in turn how they adjust and manage the condition.

One study investigated parents' decision making process of whether or not to medicate their child (Taylor, 2006). This Australian study included mothers and fathers and suggested that in the decision to mediate their children parents go through a series of processes similar to a grief process. This process includes denying the diagnosis, anger, depression and emotional turmoil, and parents eventually come to making a decision to medicate their child and adopt a stance of proactive parenting. The study highlights how parents cope with the emotionally difficult decision of medicating a child and highlights the harrowing nature of this experience for parents.

Other qualitative studies have focussed on how parents experience being a parent of a child with ADHD including how they thought and felt prior to the diagnosis. However, in some studies one or no fathers were included (Arcia & Fernandez, 1998; Bull & Whelan, 2006; Dunworth, 2001; Harborne *et al.*, 2004). In the most recent UK

based studies (Bull & Whelan, 2006; Harborne *et al.*, 2004) the difficulties that parents (mothers) felt were highlighted. Bull and Whelan (2006) found that mothers were aware that their children were atypical: they strove to raise them to symptom free maturity, and that tension between schemas caused stress and impacted on the marital relationship. The mothers also described their view of the father and the fathering role. Fathers were perceived by their partners to be ineffective and requiring supervision in their management. The father's role in management was perceived to be subordinate to their role as mother and should follow the mother's directions and principles. Yet despite this, the mothers noted that the fathers discipline was more effective than their own, although it was perceived to be by punitive methods, rather than reasoning. Harborne *et al.* (2004) included one father in the study, however the individual perspective of this father was not described. Harborne *et al.* (2004) found that some mothers had battled with their partners, as the fathers were perceived to be unsupportive and dismissive of their concerns as they held a different view to the mother relating to the condition. From the qualitative literature it seems that having a child with ADHD can cause parents considerable difficulty. However, the bias of the existing literature is towards understanding the experience from the mother's perspective.

A number of fathers have been included in other qualitative studies (DosReis *et al.*, 2005; Kendall, 1998) but the experience was not significantly differentiated between the parent's perspectives and the father's perspective was largely silent. However, Kendall's (1998) study does differentiate between mothers and fathers more so than other qualitative studies. Kendall's (1998) is the largest qualitative study of parents who have children who have ADHD. The American study used a grounded theory method and included 15 families (N = 59) which consisted of 15 mothers, 10 fathers, 20 children with ADHD and 14 non-ADHD siblings. However, only the parent's experiences were reported in this paper. A total of 109 open-ended interviews were conducted lasting from 30 to 90 minutes in length. The study found that "outlasting disruption" is central concept to living in a family who has an ADHD child. One sub-process that the study was differentiated between the mother and father's experience related to 'individuating,' whereby mothers were seen to be enmeshed in the emotional pain of their child. According to Kendall (1998) mothers over-identified with their child's (particularly with sons) difficulties and according to Kendall:

... at times, over justifying or minimising negative behaviours to defend their children “against the cruel world out there” (pp. 849)

As it can be seen from the literature discussed thus far, mothers and fathers have been found to report different experiences, perceptions and relationships of children who have ADHD. However, research has tended to view mothers and fathers simply as “parents” rather than differentiating between their different experiences. There is a lack of qualitative research investigating solely the father’s perspectives. Indeed there appears to be an under-representation of fathers in the ADHD literature. The silence of fathers in the research and clinical setting has been previously discussed (e.g. Phares, 2006; Vetere, 2004). However, it is important not to view fathers as “marginal family members” (pp. 47; Phares, 2006) given their central role within the family system. One qualitative study, however, has looked at the perspective from a fathers’ perspective and did indeed find that fathers’ had differing views and beliefs from mothers. Singh (2003) investigated father’s perceptions of ADHD symptoms, diagnosis and drug treatment. The study found that fathers’ perspectives on their sons behaviours fell into three overlapping categories of indulgent mothering, boy’s lack of motivation and a “boys will be boys” standpoint. Father’s perceptions of diagnosis and drug treatment was categorised as “reluctant believers” and “tolerant non-believers”. They had a resistance to a medical framework for their son’s difficulties and drug treatment for their son’s and identified with their sons behaviour. The study did not explore the process of adjustment to the diagnosis, but focused instead on attitudes towards diagnosis and medication.

1.4. Study Aim

To date there is only one published qualitative study about parenting a child with ADHD from the father’s perspective which focussed on diagnosis and drug treatment. Other qualitative studies have included fathers included both mothers and fathers but have not fully described the experiences from the father’s perspectives. This study aims to explore the particular experience of what it is like to be a father of a son with ADHD, from their first awareness of difficulties with their child to the present day. The study will be a qualitative investigation as this will allow an in-depth exploration

of their views, meanings and how they make sense of their experience of being a father of a child who has ADHD. It is anticipated that by using a qualitative approach this will allow for an understanding of fathers in a clinical context and thus allow services to respond to the needs of an often silent, under researched, integral part of the family system.

2. METHOD

2.1 Aims:

- To investigate fathers' experiences and perceptions of their son's diagnosis of ADHD;
- To investigate the impact of having a son with ADHD from the fathers' perspective.

2.2 Design

The current study is a qualitative investigation using Interpretative Phenomenological Analysis (henceforth IPA) (Smith, 1996), using semi-structured interviews as its method of data collection. The specific use of IPA in this study will be outlined in section 2.7.

2.3 Research context

As Reid *et al.* (2005) argue, is important for an IPA study to take into account and discuss the contextual and cultural ground against which the data is gathered. Therefore, below is a characterisation of the service from which the participants were recruited and a description of the researcher's background.

2.3.1 Characterisation of the service

The participants were recruited from a dedicated ADHD service, which is part of a generic NHS Child and Adolescent Mental Health Service. The ADHD service is based in a main town in central Scotland in an urban area. The service's team is composed by ADHD specialist nursing, clinical psychology, specialist teacher and psychiatry. Referrals are received from a range of sources including GPs and schools. Following diagnosis, medication can be prescribed where appropriate. The main non-pharmacological therapy offered is a family based behavioural intervention, which consists of a six-week group package for parents, including advice on what ADHD is and how to manage it.

2.3.2 Characterisation of the researcher's background

In order to provide the reader with further factors which provide a context to the study, below is an outline of relevant researcher characteristics.

The researcher is a 28 year old Scottish female and she has no children. She is a trainee clinical psychologist, and has been trained predominantly in using interventions that are underpinned by cognitive theory.

She became interested in the topic area of ADHD whilst undertaking a placement in Child and Adolescent Mental Health in the department from which the participants were recruited. As part of her clinical work, she carried out an ADHD assessment, which formed part of the data needed to inform the lead clinician's decision regarding a young person's ADHD investigation. She found the process of carrying out an ADHD assessment challenging. The assessment was thorough, yet there was no clear cut answer due to a variety of different reasons, including: the young person's reading difficulty; mixed reports on the young person's behaviour from different teachers; mixed reports from both parents. It was the latter point that was of particular interest to the researcher. Initially the father did not attend the clinic until the researcher requested this, in order to gain a comprehensive account of the young person at home. The researcher had reflected on the rest of her caseload and noted that it was mainly the mother who had attended the clinic with their child. When the father of this young person attended, he appeared to have a different perception and opinion on the young person's behaviour. Namely, he did not see the behaviour as troublesome as the mother and saw it as typical behaviour for a young boy. This sparked the researcher's interest in investigating fathers' perceptions of ADHD and their experience of their son being diagnosed.

2.3.3 Participants

In terms of the selection of participants, Smith (2008) recommends studying a homogenous group. Therefore, participants were identified using purposeful sampling strategy, in that the participants were chosen from the ADHD service for their closely

defined characteristics. The inclusion criteria are outlined in the appendix II. The final group of participants was homogenous in a number of aspects.

First, all fathers included in the study had sons aged between 8 and 11 who had been diagnosed with ADHD and were receiving treatment (both medication and/or other approaches) at the same clinic. This age group was chosen for a variety of reasons. In terms of developmental stages, having a closer age bracket is helpful due to the rapid cognitive, physiological, emotional and behavioural changes (Barkley, 2006) throughout childhood, and therefore raising qualitatively different issues and experiences for parents. Also, middle childhood (age 4-6) (age range stages as suggested by Newman and Newman, 2003, adapted from Erikson, 1968, cited in Carr, 2006) would be difficult to interview due to cognitive limitations. On the other hand, early adolescence (age 12-18) will typically imply that the young person attends high school, which brings with it different issues (e.g. independence related issues which may involve conflictual interactions in interpersonal interactions). Finally, qualitative studies investigating parents who have sons who have ADHD have included this age bracket (e.g. Harborne et al., 2004). This study will thus be comparable to them, which is a feature of research advocated by Willig (2001):

“Rather than relying on one isolated qualitative study, we aim to integrate the findings from a number of comparable studies to draw wider conclusions to be made” (Willig, 2001, pp18)

Second, all participants were biological fathers of a son with ADHD. This was selected as an inclusion criterion as the experience may have been different for step-fathers. Being a blood relation is also important as studies have shown an elevated risk of ADHD in biological relatives (Barkley, 2006) therefore this may influence the fathers’ experience.

Third, all fathers lived with their son and their son’s mother. This was selected as a criterion as the study is concerned with the lived experience of having a son who has ADHD (which might be compromised if the father did not live at home with their son).

Forth, all participants had a son with a diagnosis of ADHD (as opposed to a daughter), as male children are more likely to be diagnosed with ADHD². This contributed to the typicality of these participants in relation to a wider group of fathers of a child with ADHD.

In terms of the sample size, Smith (2008) states that there is no correct answer concerning the number of participants needed to carry out an IPA study. It was, however, argued by Turpin *et al.* (1997) that for a Doctorate in Clinical Psychology thesis a minimum of five participants are generally required (with the possibility of exceptional cases). According to a recent publication Smith and Eatough (2007) agree that a sample between six and eight participants is appropriate in this context.

2.3.1.1 Characterisation of the Final Group of Participants

Overall, eleven participants took part in this study. Two interviews were used as pilot interviews with the aim of developing the researcher's interview technique. Finally, one interview was not used in the final analysis as the implicated child had been diagnosed with Aspergers Syndrome, which was thus the main focus of the interview for the father.

The socio cultural background of participants is outlined in appendix III. The final group of participants was composed by eight fathers of sons with an ADHD diagnosis. The fathers' age ranged from 36 to 60. Their educational level was not ascertained during interview and their socio-economic status could be characterised as working class. They lived in an urban setting.

2.4 Recruitment

² Prevalence rates vary with male to female ratios in clinic-referred sample ranging from 9:1 to 6:1, and in population based studies approximately 3:1 (Gaub & Carlson, 1997). Males and females are also qualitatively different in terms of their presentation, with females who are diagnosed with ADHD being typically inattentive, whereas males tend to present with more hyperactive symptoms (Arnold, 1996). Therefore, the parents' experience would also be a qualitatively different.

In March 2008 the lead clinician of the above-mentioned ADHD service identified 27 fathers who fitted the inclusion criteria, and these were then sent an information pack outlining the details of the study. This pack included:

1. A cover note from the lead clinician of the ADHD service, so that families were able to understand why they had been contacted (see appendix IV);
2. An invitation letter from the main researcher to take part in the study, which a) briefly outlined the study, b) provided instructions on how to take part, and c) emphasised that participation was entirely voluntary and would not affect their son's care (see appendix V).
3. A more detailed information sheet, designed to enable potential participants to make an informed decision as to whether they wished to take part in the study; this sheet included information on the purpose of the study, details on how the study was being conducted, confidentiality assurances and arrangements, and what the study would involve for them; finally, the potential participants were invited to phone the researcher if they had any queries (see appendix VI).
4. An 'Opt-In Slip', which, when received by post at the ADHD service, would signal the individuals' interest in taking part and their agreement in being contacted directly by the researcher (see appendix VII).

Participants were recruited when they posted back to the ADHD service the 'Opt-In Slip' mentioned above. Once the researcher received this, she contacted the participants by telephone. This allowed the participants to ask any questions about the study and arrange a time and date for the interview. This phone call was followed with an appointment letter confirming the time and date. There was a minimum of a two week period between the phone call and the appointment, to allow the participant further time to consider the study. A total of 27 information packs were sent and 11 participants opted into the study.

When the participants attended the ADHD service for the interview, the researcher outlined the details of the study as they appeared on the information sheet, again to ensure that the participants understood what the study involved. Confidentiality was also discussed at this point. Participants were informed that the information they gave was anonymous and confidential to the study. However, they were also made aware of one exception to the latter assurance (i.e. if any information was disclosed that

indicated harm to themselves or others, the researcher was duty bound to break confidentiality), as issues of child protection were particularly pertinent here. After this initial chat, participants were asked to sign a consent form (see appendix VIII).

2.5 Ethical Issues

Prior to commencing the research process, ethical approval was granted by the local NHS Research Ethics Committee (see appendix IX) Following this, research and development management approval was granted from the local NHS department (see appendix X).

The BPS document, *“Good Practice Guidelines for the Conduct of Psychological Research within the NHS”* (2005) states: “As researchers, psychologists must be sensitive to the impact of their research on participants”. Ethical principles in carrying out any kind of research are similar, whether it is qualitative or quantitative. However, in qualitative research there are a number of issues that are more pertinent that need to be addressed. Qualitative research is generally interested in a person’s perspective on a subject, which requires the person to want to share this experience with the researcher. Thus, it is important to be mindful of ethical issues and the impact that the research may have on the participants throughout the research process. Orb *et al.* (2001) and Richards and Schwartz (2002), outline ethical issues that relate to qualitative research. These will be explored in turn below.

2.5.1 Autonomy

Orb *et al.* (2001) describe autonomy as relating to informed consent. In particular giving participants enough information to allow them to make an informed decision as to whether they want to accept or refuse to take part in the research. Written consent was sought once the fathers attended the clinic to do the interview. Again, the purpose and procedure of the study was reiterated at this stage.

Informed consent was treated as a process (Richards and Schwartz, 2002), in doing this it was highlighted to participants that they could withdraw from the study at any time. At the end of the interviews it was checked with the participants that they were

in agreement with the researcher sending them a summary of the interviews to check that they agreed it was an accurate reflection of their narrative.

2.5.2 Beneficence

Orb *et al.* (2001) describe this as relating to doing good for others and preventing harm. The authors highlight that interviews can potentially be distressing if the topic is a sensitive area. The research aim was to investigate fathers' experiences of their son being diagnosed with ADHD, and the issues that may surround this, which were potentially sensitive topics, depending on how this experience had been perceived by the father.

Therefore, prior to the study the researcher investigated local counselling services in the event that fathers' wished to access these. Equally, the head of the Child and Adolescent Mental Health service was available to give the participant advice and support, if needed. During the interview, the researcher monitored participants' anxiety and distress, the importance of which is emphasised by Richards and Schwartz (2002). The researcher observed the effect of the questions that were asked, by noticing non-verbal cues and the manner in which the participant responded. If it appeared that the participant felt very uncomfortable or emotional about a particular issue or question, this line of questioning was not pursued, unless the participant explicitly stated that they wished to continue.

Richards and Schwartz (2002) discuss the importance of being aware of power imbalance in qualitative interviews, particularly if the interviewer is a health professional at the clinic that the participant attends. A number of strategies were used to reduce the impact of this issue, which are addressed later in this section under that heading 'sensitivity to context'.

After the interview was finished, the researcher debriefed the participants by asking if they had felt comfortable with the interview and if there was anything that could be changed to assist in making them feel comfortable. All participants reported that they were happy, and felt comfortable; therefore no changes were made to the interview format.

2.5.3 Confidentiality

In line with Orb *et al.* (2001) recommendations a number of strategies were used to maintain confidentiality, including the use of allocated numbers as participant identifiers (participant identification number, PIN) in the transcripts and the storage of transcripts and digital recordings (this is further addressed in section ‘data management’). Additionally, as discussed in section ‘recruitment’ participants were fully informed of the boundaries of confidentiality and no personal information was disclosed to any parties, bar in one exceptional circumstance related to an issue of child protection. In this case, a participant described during his interview that his son’s behaviour had escalated in the weeks prior to interview, and his father described not knowing what to do. Therefore, the researcher gained the participant’s verbal consent to consult with the lead clinician of the ADHD service who confirmed that an urgent appointment had already been arranged.

During the whole process of this study’s execution and write up, the research was mindful of issues related to confidentiality arising from the setting of this project (an ADHD specialist service), and sought at all times to protect the participants’ identity.

2.6 Data Collection

2.6.1 Interviews

The researcher carried out semi-structured interviews with participants throughout April and May 2008. Semi-structured interviews were chosen as qualitative methods need an approach to data collection that is flexible and sensitive to the context in which the data is being generated (Mason, 2002), rather than a structured or standardised data collection tool. Smith (2008) reports that semi-structured interviews are the exemplary data collection method for IPA.

Pragmatically, semi-structured interview was the preferred approach, as it allowed the researcher to gain access to the participants experience, perceptions, understandings, interpretations, views and knowledge (Mason, 2002). Therefore this was the best approach to attain the study’s aims. This approach also allowed the researcher to

establish a rapport with the participant, to be flexible in the order in which the questions were asked and probe interesting areas that arouse during the interview (Smith, 2008). This means that the researcher follows the participant's interests and concerns, allowing an in depth understanding of that person's psychological and social world (Smith, 2008).

A focus group approach was initially considered. However, it was felt that a group may be for some of the participants an aversive setting within which to discuss sensitive issues (Willig, 2001), and that this could potentially be a barrier to participants feeling comfortable in sharing their understandings, experiences and meanings.

Semi-structured interviews require skill on behalf of the researcher, in that the researcher needs to 'think on their feet' during the interview itself (Mason, 2002). The researcher also needs to be mindful of process and interaction-related aspects of the interview, as well as the content of what he participant is saying. Semi-structured interviews require the researcher to be reflexive and active in the research process, and to be analytical in their role within the research.

Mason (2002) describes interviews as 'conversations with a purpose' in that the researcher has thought about what they would like to cover before the interview, but that the participant needs the space and opportunity to discuss what is important to them. In this sense, the researcher will have a particular agenda and follow specific areas of enquiry that interests them. However, it is accepted that that interviews are not 'standardised' in the same way that other methods are. However, the researcher interests and perspective cannot, of course, be eradicated from this type of approach (Mason, 2002).

2.6.2 Interview guide

The interview guide was developed following the guidelines for IPA studies in Smith (2008). Smith (2008) recommends that the interview schedule should allow the participant to speak about the topic with as little prompting from the researcher as possible. The questions were designed to be open. Prompts were constructed to gently

guide the conversation, where needed. The questions were developed in reference to literature in the area of ADHD and parenting a child who has ADHD.

The interview guide was agreed by the researcher's academic supervisor and another supervisor who specialises in qualitative research. The questions were put in the most appropriate sequence, beginning with the diagnosis and then moving onto how having a son who has ADHD impacts on daily life. There were two main questions and prompts which lead from these questions. The full interview format is in appendix XI and the interview schedule is shown below:

1. What was your experience of your son being diagnosed with ADHD?

Prompts

- What did you think and feel (about your son's problems, the diagnosis and treatment)
- How did your experience compare to that of your wife/ partner's experience?
- How did the experience affect your relationship?

2. How does having a son with ADHD affect your daily life?

Prompts

How does it affect:

- Life at home
- Relationships
- Emotionally
- Practically
- Work

2.6.3 Data Management and Transcription

The interviews were recorded using a digital recorder. These were then transferred to the researcher's computer and the recording was deleted from the digital recorder. The researcher transcribed all the interviews. The data was transcribed to include all the words spoken and the following discursive features: false starts, noticeable pauses, significant inflections on words (e.g. emphasis or pitch) and laughter (see a list of used transcription notation in appendix XII). At the point of transcription all identifiable information that the participant stated during the interview was removed. The process of transcribing all the interviews allowed the researcher to become familiarised with the data and to become immersed in the participant's experience. Following transcription they were analysed by hand, see data analysis below, and files were

then transferred to NVivo 7 (NVivo qualitative data analysis software; QSR International Pty Ltd. Version 7, 2006). All documents were password protected to ensure data security.

2.7 Data Analysis

The main research aim here was to gain an understanding of fathers' experiences and perceptions of their son's diagnosis therefore a qualitative. A phenomenological approach was chosen to gain a rich textured description of lived experience by asking what an experience is like and what it means to the person. The specific phenomenological approach chosen was IPA the following section aims to provide an account of the rationale underpinning this choice of analytical model and its adequacy for this study.

Interpretative Phenomenological analysis (IPA) was chosen for this study for the following reasons. Firstly, IPA fits the research aims as it is hoped that research will enrich the literature and knowledge on fathers' perspectives and experience of having a son who has ADHD, by describing what this experience is like, and how they make sense and perceive this experience. Indeed, IPA allows the researcher a further insight into the 'lived experience' of a phenomenon or an event, from the perspective of the person who has experienced it (Reid *et al.*, 2005) rather than attempting to produce an objective statement of the event or phenomenon. Secondly, IPA actively acknowledges the researcher in the interpretative process. Although IPA aims to gain an 'insiders perspective' (Conrad, 1987) of the phenomena, Smith (1996) argues that this is mediated by the researcher's own conceptions and understandings of the participant's personal world. Indeed acknowledging the researchers perspective and how it may have shaped the analysis is a central demand of good qualitative research (Finlay, 2002). Finally, according to Smith (2008), IPA has an emphasis on sense-making by the participant and the researcher. Therefore, cognition is a central analytical matter. This also appeals to the researcher as her background in clinical psychology has meant that cognition is a key underpinning in her understanding of participants experiences.

2.7.1 Brief background to IPA and relevant concepts

According to Smith (1996) IPA has two important theoretical underpinnings: phenomenology and symbolic interactionism. Although the author notes that phenomenology has a long and controversial history within social science, Smith (1996) traces the roots of phenomenological psychology to Husserl's philosophy. He characterises its main concerns as the individual's personal perception or account of an object or event, rather than producing an objective statement about an event or object (Smith and Osborn, 2008). Symbolic interactionism argues that the meaning that people ascribe to events are obtained through a process of interpretation and that meanings are made sense of in social interactions (Smith, 1996).

IPA as a process begins with an idiographic case analysis. It is thus concerned with the particular and the individual (Smith *et al.*, 1995), in contrast to nomothetic studies. Although IPA can be used in single-case studies (e.g. Eatough & Smith, 2006) it generally progresses as a process of analysis from the individual to the common or shared experience, meanings and patterns across a group.

As it was already addressed above, Smith and Osborn (2008) acknowledge that, obviously, a researcher cannot fully attain an 'insider's perspective' of a participant's experience. In this sense, the authors describe a "double hermeneutic" (Giddens, 1982) is involved in the interpretation process. Unlike other qualitative methods, in IPA the researcher explicitly enters into the research process as a subjective and reflective process of interpretation (Reid *et al.*, 2005). According to Smith and Osborn (2008), access to the participant's lived experience depends on their ability to make sense of their experience and articulate this. In turn, the researcher is trying to make sense of how the participant makes sense of it. IPA is thus openly interpretative, and this process of interpretation of a participant's experience and meanings is based on the researcher's background, knowledge and conceptions. The idea of a double hermeneutic in IPA can also be understood in another way, as it combines an empathic with a critical hermeneutic (Ricoeur, 1970). In addition to endeavouring to understand participants experience from their perspective, IPA involves another researcher-position, in that he/she take a step back from the data asking curious or critical questions. Smith and Osborn (2008) provide examples of this, such as asking

what the person is trying to achieve, whether something is being said that is unintentional. IPA interprets the inferences from the data cautiously and within the contextual and cultural background in which the data is generated (Reid *et al.*, 2005).

2.7.2 Process of Analysis

In accordance with IPA approach outlined by Smith (2008) and Smith and Eatough (2007) the data was analysed using the following process.

Starting at the transcription phase, as the researcher familiarised herself with the data, she made notes on any initial thoughts and comments (Smith and Eatough, 2007). Once the transcripts were produced, these were read several times so that the researcher immersed herself in the content. This allowed both a holistic perspective on the data and detailed knowledge of the interviews which is crucial in assuring that future interpretation is strictly grounded in the data (Smith and Eatough, 2007).

In terms of a procedure, each transcript was analysed individually and in turn, assuring an initially idiographic approach to the data. The left-hand margin of the transcript was used to note any initially significant or interesting sections of data. This included paraphrasing of participant's meanings, associations and connections as well as preliminary interpretations (Smith, 2008). As the transcript was re-read, the right-hand margin was used to make notes on emerging themes in the data, thus, from a bottom-up perspective. This stage implied a higher level of abstraction compared to the first readings of the transcripts, as the researcher alluded to and used psychological concepts and terminology (Smith, 2008). However, throughout this cyclical process, special care was taken to remain connected and faithful to participants own words and meanings (Smith and Eatough, 2007), i.e. strictly grounded and faithful to the data.

Once themes were identified they were written into a chronological list. Next, links between themes were noted and clusters of theme began to emerge. As the clustering of themes progressed, these were checked against the transcript to ensure that the connections worked in relation to the own words and meanings of the participant (Smith, 2008). For each participant and transcript, a coherent table of themes was

then produced, including the super-ordinate themes and the subordinate themes that comprise it (Smith and Eatough, 2007) (see appendix XIII for an example table). A sample of a coded transcript is also included in appendix XIV.

In continuing the analysis of each participant's transcript, the themes and structure that had emerged from previous transcripts were used insofar as they provided a general backdrop to the analysis of the new transcript (Smith and Eatough, 2007). Mindful of the idiographic focus of the analysis, the researcher noted new themes and, subsequently, the convergences and divergences in the transcripts. The researcher remained aware of each transcript and reviewed previous transcripts to ensure that prior instances of the new themes had not been overlooked, as well as finding responses that further articulated existing themes. Finally, once each transcript was analysed a master table of themes that emerged for the group of eight participants was constructed (see appendix XV). A summary of the analysis was then sent to the participants to allow the participants an opportunity to check that the analysis was an accurate reflection of their experiences (see appendix XVII).

2.7.3 Reflexive Diary

The researcher sought to maintain integrity and trustworthiness of the research by maintaining a reflexive diary throughout the process of research (Finlay, 2002). Any personal ideas and transactions that emerged from the research were documented and reflected on. This included reflections on interviews, including initial working hypothesis, highlighting key themes and the possible meaning for that individual, whilst being aware of my relationship/ perspective influence in these processes. Excerpts from the reflexive diary are included in the section 4.5.

2.8 Relevant Methodological and Validity Issues

Validity, reliability and generalisability are concepts that are well acknowledged in quantitative research. However, there has been debate over what constitutes good quality qualitative research and how this can be judged. A number of suggested criteria have been proposed (e.g. Turpin *et al.*, 1997; Parker, 2004; Government Chief Social Researcher's Office, 2003; Yardley, 2000, 2008; Elliot *et al.*, 1999). In the

following section the current study will be discussed in line with the principles suggested by Yardley (2008) as these are the one of the most recent guidelines and apply to all qualitative methods including IPA. The main categories for increasing validity highlighted by Yardley are: sensitivity to context; commitment, rigour, coherence, transparency and impact and importance.

2.8.1 Sensitivity to Context

In order to achieve sensitivity to context this study linked the analysis to current psychological, philosophical theories and empirical literature in the introduction and the discussion. In carrying out the analysis awareness was also paid to the participants narratives in the context of their historical and socio-cultural background.

The context in which the research was carried out was considered at the design stage. By carrying out the research in real life settings such as home, higher ecological validity may have been achieved (Willig, 2001). Indeed carrying out the home setting removes the interview from the clinic. This might have allowed the participants to feel freer in their responses in terms of discussing their personal experiences rather than what they think the researcher wants to hear, perhaps due to concerns that what they say may impact the perceptions or care of their child in the healthcare setting (Yardey, 2008).

However, for this study interviewing at home was not an appropriate setting for data collection. This is due to the nature and questions of the study. The study is asking fathers to discuss their experience of their sons. Because it was possible that members of the family would be in the house at the time, carrying out the interviews at home posed ethical ramifications. Also, it would not provide the confidentiality and space that might be needed to discuss the experience. As the father may wish to discuss the mother of the child, again this poses the same ethical problem. Therefore all the interviews were all carried at the clinic at which their son had been diagnosed and attended. In any case, all interviews were carried out in what the service calls the 'family room' and not carried out in any of the clinical rooms, where the families may have attended for the assessment.

As discussed in 'ethical issues' it was important to reduce any power imbalance that may exist as a result of the researcher being a clinician who previously worked in the department. The researcher wore casual clothes, the participants were offered refreshments and snacks, and the researcher chatted to the participants prior to the interview to allow a friendly, relaxed atmosphere. The researcher also emphasised that the study was for fulfilment of an academic qualification, and emphasised that although the findings of the research would be presented to the ADHD service, anything that they said would not directly impact on their son's care.

2.8.2 Commitment, Rigour, Transparency and Coherence

The researcher maintained the validity of the study by carrying out a thorough in-depth analysis using IPA methodology. In order to achieve rigour using an IPA methodology, in addition to reading IPA literature, the researcher attended a one day training event in IPA. The researcher also accessed a web based IPA forum (<http://groups.yahoo.com/group/ipanalysis/>) which receives regular contributions from prominent IPA researchers.

The study included a sufficient number of participants (see section 2.3.3 for discussion on the sample composition), which provided a wide range of participants to allow many different perspectives to be included. The interviews were carried out and transcribed by the researcher thereby allowing the researcher to become immersed in the data. The initial interviews, once anonymised, were reviewed by a researcher supervisor in order to develop the researcher's interview technique. In addition, two research supervisors read over half the transcripts and the coding was compared to triangulate perspectives. A thorough understanding of the participants' experiences was enabled by the researcher's in-depth engagement with the transcripts, which were read and re-read to gain any new perspectives or insights. The in-depth analysis included interpreting the use of language in the person's narratives. All transcripts were cross referenced and a master table was developed. This allowed the researcher to seek both diversity and patterns in the data, ensuring that the rigorous process of analysis was focused not only on the similarities emerging from participants' narratives, but also on disconfirming instances to these patterns (i.e.

where one participant's experience did not 'fit' with the dominant themes across the sample). This ensured that an idiographic approach was maintained and important experiences for that person highlighted. The final master table (see appendix XV) illustrates both similarities and differences in experiences across the group.

Transparency was enhanced by a detailed description of how data was collected and analysed. There is also sufficient detailing of the study in the paper trail for independent audit. As it will be possible to see in the analytical sections of this thesis, detailed verbatim quotes are incorporated throughout. These include an indication of their location in the transcript (according to line numbers) and, where relevant, are preceded by the question that elicited the narrative. These verbatim extracts illustrate the link between the themes and the person's narrative, allowing readers to judge by themselves the validity of the researcher's interpretation and its faithfulness to the data. Moreover, to illustrate the coding process, an example of a coded transcript is included in the appendices (see appendix XIV). A table of themes from another participant's narrative is also included (see section XIII). In addition, a summary of the results were sent to the participants as a means of triangulating the data, to ensure that the participants had the opportunity to report whether the results were an accurate reflection of their experiences or not. No participants contacted the researcher to discuss the results; therefore it is assumed that the results are an accurate reflection. As discussed, the researcher kept a reflexive diary throughout the study (see section 4.5). In addition the researcher provided relevant details of her own interests and characteristics relevant to the study to allow the reader to explore the ways in which the researcher may have influenced the study (see section 2.3.2).

2.8.3 Impact and Importance

The study provides an in depth analysis of fathers experiences of having a son who has ADHD, an area of which there is a dearth of knowledge. This study highlights a number of clinical implications such as the fathers' differing stages of acceptance in comparison to mothers, as well as fathers differing attributions for their son's condition and behaviour and a description of difficulties in managing their son's behaviour. The study highlights a number of recommendations and ideas for future research, which are fully discussed in section 4.3 and 4.4.3.

3. RESULTS

3.1 Themes overview

Six superordinate themes emerged across the narratives: *“the search for answers”*; *“working with the diagnosis”*; *“perplexed parenting – parenting a son who has ADHD”*; *“the battle to balance family life”*; *“heightened sense of parenting responsibility”* and *“managing uncomfortable emotions”*. Superordinate themes were comprised of 17 sub-themes represented in a schematic diagram in appendix XVI. The distributions of sub-themes across all participants are represented in the master table in appendix XV.

The participants talked in differing levels of detail: participants P01³, P02, P03, P05, P06 P07, and P08 were represented in the majority of sub-themes. P04’s experience represents an exception within this group of fathers. As such he is an important presence, as he is a father who differs from the other participants in that he instigated the diagnosis investigation, rather than the child’s mother. We can thus hypothesise that, perhaps he had fewer difficulties adapting to the diagnosis, and perhaps felt more in control of his situation. It will be seen that in relation to some themes he represents an exception to the trend of the group. The socio-cultural backgrounds of the participants are represented in appendix III.

Each superordinate theme will be introduced and the sub-themes described along with verbatim quotes to illustrate the theme. The themes are interlinked and this will be highlighted throughout the results. In order to maintain an idiographic approach themes will be discussed with relevance to the person’s social and personal world. Key exceptions to the theme will be discussed along with the possible reasons. The results will be linked to relevant literature in a separate section: *discussion of themes*.

3.1.1 Superordinate theme: the search for answers

³ Participant identification number (PIN)

Throughout all narratives the superordinate theme “*the search for answers*” emerged. However, for all fathers, with the important exception of P04, the journey to diagnosis was not initiated by them. This was a journey that follows the trail made by the son’s mother⁴. This journey was difficult, complex, and fraught with mixed emotions. For all fathers the arrival at diagnosis was only the start of the journey which continues with ongoing mixed emotions and thoughts.

3.1.2 Fathers’ awareness that something is not ‘right’

In their retrospective accounts, most fathers described varying levels of early awareness that their sons appeared to be ‘different’ (P05; 49⁵) or ‘problematic’ (P08; 59). Most fathers were confused and had attempted to make attributions to explain this.

Some fathers internalised attributions and questioned their competence as a parent; this is illustrated by P03 in the excerpt below:

Extract 1: P03; 60 - 64

I was trying to show him what to do, how to behave and that like but he wissnae [was not] picking it up. An’ I’m going is it ma parenting skills here or not? Because I spent a lot of my childhood in children’s homes. So I didn’t have actually have much of an actually close family upbringing, myself like. An am going, what am I doing wrong here? Cause it’s got to be me if he’s no behaving and he’s no learning to behave properly.

In the excerpt above the internalisation of blame appears to be a mechanism of his perceived lack of a parenting model due to his own upbringing. Although not all fathers perceived a weakness in their parenting model, the excerpt typifies that, for some fathers, pre-diagnosis awareness was at a level where they were searching for answers. This was often linked with early internalised blame, heightened emotions and confusion and was a particularly strong theme for P04, P07 and P03.

For P03 the theme of blame continued throughout his narrative and was further compounded once the diagnosis was made, where he questioned his role in causing

⁴ The father’s spouses will be referred to as “the mother” throughout the document.

⁵ Range and location in the transcript of lines spanned by the abstract

the diagnosis. For P03 the possibility that he may have caused ADHD, and thus his son's chronic condition, is related to an ongoing feeling of hopelessness:

Extract 2: P03; 532 - 537

I felt sad, you know what I mean? That, that was the way he was. You know? Was it something fae [from] me, you know? Was it a genetic problem fae me or, anything like that you know? And I just just, I mean, I still do, I still get upset about it every so often, em cause, I mean eh, he's got something that will never really be cured cured, as such. Em, and you just go "Is it something that we've gave him, through our genetic make up ourselves?" Cause it has to come from somewhere.

Blame for causing his son's condition was also a significant issue for P01 as discussed in "*managing uncomfortable emotions*" (extracts 70, 71 & 72). However, prior to his son's diagnosis he attributed the child's difficulties to behaviours within the normal range. This trend continued after his son was diagnosed:

Extract 3: P01; 154 – 155

I: So you came along, and the diagnosis came about and you heard the term ADHD – what was your first thought?

R: I thought it was a lot of rubbish to be honest, I thought it was absolute tosh, I could use stronger language than that but ...

I: You can if you want!

R: I did, I thought it was all bullshit. I really did, I thought it was all fucking rubbish. I said "[Son's] just being a typical boy" Still got that in my head. Even now at times I still go ((sigh)) "take his tablets away".

In the extract above we see the strength of belief that his son's behaviour was not as a result of a medical condition, and his ongoing struggle in accepting the diagnosis. This is a particularly strong except however, it typifies fathers' normalising their son's behaviour, which was also a strong theme in the narratives of P01, P02, P05 and P08 pre-diagnosis. Certain levels of normalisation were evident following diagnosis for all fathers to varying degrees. This was possibly linked with difficulties in accepting the condition, as described in the superordinate theme "*guarded acceptance*" or linked to the difficulties differentiating between 'normal' behaviour and behaviour that is linked to the condition, as further discussed in "*perplexed parenting – parenting a son who has ADHD*".

3.1.3 Fathers' following the journey that had already begun

With the exception of P04, for the most part, the mothers typically instigated the journey to diagnosis and fathers followed. Some fathers were reluctant passengers on

the journey to diagnosis. There was a theme of scepticism in contrast to the mothers' "adamance" (P08) that something was different about their son. This was a particularly strong theme in the narratives of P01, P02, P05 and P08 who illustrates this below:

Extract 4: P08; 6 - 9

She was kinda adamant for 3 or 4 years but, I mean I'm no saying I was in denial of the fact of him, ah dunno if it's a man thing or no but eh with him being our first born I was thinking there cannae be anything wrong with him because he's ma son y'know I was kinda in denial in a way...

From the above excerpt we see strength of the P08 scepticism, as the issue had been raised for a number of years. In the above excerpt we also see P08 reflecting why he did not accept that his son may have a problem. The process of working out his reaction appears to be a dynamic process that was discovered in the interview ("I'm no saying I was in denial" "y'know I was kinda in denial"). The above excerpt typifies the difficulty for some fathers to accept that their son had a 'problem' and appeared to be related to the normalisation of their sons problems described above. This also highlights the difficulties arising/ created by divided opinion between parents which is further discussed in "*maintaining a balance with mothers*".

However, some fathers' were more willing passengers and open to the journey to diagnosis, in particular P06 and P07. P03 was abroad with the armed forces at the time of diagnosis and so described little of this journey.

In the excerpt below P06 describes openness to the possibility that his son may have a medical condition:

Extract 5: P06; 90 - 93

... until [mother] says to me "there's something wrong wi' him" then I started thinking you know all the things that have happened in the past. Oh aye, right enough, when he was doing this, and doing that, just stupid wee things, that I just, I didnae ignore it at the time when it was happening, I just didnae think anything of it.

The above excerpt we see that P06 had not questioned that there was something wrong until the mother suggested that there may be a problem, which resulted in a retrospective analysis of his son's behaviour.

P07 had particular difficulties in terms of his son displaying aggressive behaviour. His son had hit both him and the mother and was a behaviour that had occurred for a number of years. Therefore he was very aware that his son's behaviour was out with the normal limits of childhood behaviour, and thus was open to the fact that his son may have a medical condition:

Extract 6: P07; 6 - 9

...for awe these years we've hud [son] facing up to me, fighting me, punching his mum, kicking his mum, actually knocking her down on the floor swearing, and we didn't know what was causing it, everything's going through your mind, your thinking brain tumours ...

The above extract emphasises level of unacceptable behaviour that his son was displaying and the degree of seriousness to the point where he had questioned whether he might have a neurological condition. Although across some narratives fathers described their sons being aggressive and angry, this level of aggression directed towards the parents was an exception.

3.1.4 Observing the diagnosis: fathers' removed involvement

Once the fathers followed the mothers on the journey to diagnosis, a theme of fathers being observers in the diagnostic process emerged in most of the narratives. For some fathers (P01 and P08) there was an expression of regret that they had not been heavily involved in the process. For P08 this related to his initial scepticism that his son had a problem. Some fathers were removed from the diagnostic process through personal circumstance, which meant they had little or no choice about their level of involvement and relied on second hand information from the mother. P03 was stationed abroad for work whilst the diagnosis was made:

Extract 7: P03; 520 - 526

I felt like I was lost out there, know what I mean? I was out there, there was nothing I could do, I couldnae [could not] alleviate the problem any, I could speak to him on the phone – that's all I could do. It it was frustrating... And it was it was just so frustrating, cause there was nothing I could do, I mean I just basically had to agree with her, I says "When I come back we'll talk about it".

In the excerpt we see the physical removal of P03 from the situation renders him powerlessness to the influence the situation, and leaves him feeling useless. However, the theme of powerlessness and the mothers being the main agents of change typified

most of the fathers' experience, including fathers who attended the department. P05 who had initially been sceptical attended the clinic with the mother and describes this:

Extract 8: P05; 621 - 630

I was more observing what was going on I think, eh my wife was more em, having an input, I was ok with that, cause it was her that spent most of the time with [son], I mean as I said to you, I mean I was working, I work a lot of hours, so she spent more time with him so obviously it more sense for her to speak to the doctor about it I mean I wanted to be here, I mean I wanted, I had questions I wanted to ask, I wanted to know what was going to happen, I went to the school meetings as well, for the same reason, I wanted to know what was going to happen with his education, what they were going to do about the situation.

In the above excerpt we see a sense of frustration in relation to his involvement. This tension appears to arise from what he “wanted” and he could do. However, like some of the other fathers who worked, there was an attribution to the mother of the son's behaviour, and therefore, a greater influence in the diagnostic process.

For some fathers it appears the lack of involvement was linked with emotional implications. This was strongest in P08 and P01 narrative as P01 describes:

Extract 9: P01; 144 - 150

R: I came a couple of times. [mother] dealt with most of it. I don't know if that's how, I'm not resentful, I'm not resentful in any way, looking back is that how I sort of, is that how I thinking to myself, maybe I should have been more involved as well with the diagnosis process and things like that...

I: why are you thinking that?

R: I really don't know. Maybe I'd understand it a wee bit better if I'd been with some of the visits earlier on with [mother].

Extract 10: P01; 72 - 73

...what chance has he got of understanding it if I can't understand it, and that's another guilt trip.

From the above excerpt we can see P01 expressing regret. His feelings of confusion and desire to understand ADHD more was a prominent theme throughout his narrative, as it will be possible to see in “*perplexed parenting*” (extract 26).

3.1.5 Fathers' guarded acceptance

The diagnosis of ADHD was met with intense and mixed emotions by all the fathers. All fathers described a fear of the diagnosis as the prognosis is linked to poor outcomes for some children such as crime (this is further discussed in “*heightened sense of parenting responsibility*”). The sub-theme of “*guarded acceptance*” emerged

in most narratives. Acceptance was a complex process for most of the fathers, and was never a complete acceptance: they accepted that their son had a problem, and that the diagnosis allowed them to help their son; yet they struggled to fully assimilate the diagnosis.

Some fathers described the emotional impact of the diagnosis:

Extract 11: P07; 49 - 51

...I was devastated, coz I just I just wanted ma wee boy to grow up as a normal wee boy and I had visions of all these tantrums, fights getting out of hand, getting into trouble ...

In the above excerpt we see the huge emotional impact of diagnosis and catastrophic vision of the future which typified the reaction to the diagnosis for many fathers. In contrast, some fathers expressed relief as the diagnosis explained their son's behaviour and felt more empowered to manage it:

Extract 12: P06; 408 - 410

... it lets us look out for things, a lot easier [line suppressed 408 – 409] it gave us the answers we were looking for basically ... when he described the diagnosis and that, and he was telling us about it awe, and that, and we're going "Ahh, that's probably why he was like that" ...

Some fathers expressed relief that the diagnosis gave access to the support that they felt their son needed and allowed them to help their son:

Extract 13: P02; 167 - 169

...diagnosis wise when it did happen we weren't surprised by by that point because we always, because by then we knew there was a problem and it was a case of just getting starting to get help for [son]'s sake...

Extract 14: P02; 189 - 192

... with the diagnosis was made and it made a massive difference to him the fact that he started getting the help that he should have been getting, we still had to push the school, all the time, ken [know] we hud meetings regular meetings...

In the above excerpt P02 describes having to 'push' the school, being proactive and pre-emptive. This typified the experience for most fathers and is further discussed in "*heightened sense of parenting responsibility*". The above excerpt describes the *joint* parents' acceptance of the diagnosis as it validated their thoughts and empowered them to help their son. However, the complicated nature of acceptance is described below where P02 later describes his personal difficulties in accepting the diagnosis:

Extract 15: P02; 208 - 220

... when they said ADHD I mean ... [mother] immediately starts ... reading up on it, she was looking up websites ... and saying “Oh this is [son]” and he does this, and he does that. Whereas I was, like, .. ken, gonnae read about this “I know, aye aye” “I will I will” and I never ever done it, eh to be honest like, because its just like, I’ve got my way of accepting things ... I was a bit taken a while to accept the fact that he did huv it and eh it caused a few arguments in the house, like obviously ken, cause [son] would do behaviour, [mother] would put it down as ADHD and I put it down as just being, a wee pain, if you put like, and just kinda just give a row for something, come on, ken “That’s ADHD” “You need to learn” “You need to read up on that”...

In above excerpt we see P02’s personal difficulties in accepting the diagnosis and, as a coping strategy, he avoids learning about the condition. The above series of excerpts illustrates the complicated nature of guarded acceptance for the majority of fathers. The above also highlights the shifting boundaries that result from the ADHD diagnosis, as fully discussed in the theme “*perplexed parenting – parenting a son who has ADHD*” and the impact on the relationship between the mother and father as fully discussed in the theme “*the battle to balance family life*”.

3.2. Superordinate theme: working with the diagnosis

Having a son diagnosed with ADHD meant that fathers had to “work with the condition”. For all fathers this involved the consideration of medication. However, this medication was a highly emotive subject for most fathers and a theme of dilemma emerged.

3.2.1 The first dilemma of medication

The sub-theme of “*the first dilemma of medication*” was present in the narratives of all participants. Across all narratives, fathers described the negative reports of medication in the media that left them feeling shocked and scared. For most fathers this left them in a dilemma, as P05 illustrates:

Extract 16: P05; 351 - 356

... there was stuff that we read on the internet when we looked into it, it was quite, some of that stuff is really quite frightening [lines suppressed 353 – 354] both myself and my wife were really concerned about that, but then once we spoke to the Doctor, he put things in a different perspective, I think you’ve got to realise, you’ve got to look at the bigger picture ...

P05 earlier described the ‘bigger picture’ which involved reappraising his concerns:

Extract 17: P05; 174 - 179

P05: ... rather than look at the negative stuff, lets look at the positive stuff, lets see eh what a difference it will make to his behaviour ...

The above excerpt highlights the shift in thinking where fathers began to focus on the benefits of medication. P05 describes focussing on the positive side. However, he continued to feel the dilemma of medication, through ongoing side effects, as described in the theme "*managing uncomfortable emotions – moving on*" (extracts 75 & 76).

For most fathers this was a forced shift in thinking where they had no option but to accept medication for various reasons, such as their sons' struggle in their academic progress and the impact of their son's behaviour on others. For P07 he appeared to be forced into submission with the intensity of his son's behaviour. He felt powerless to control his son's behaviour and felt he had no other alternative but to try medication:

Extract 18: P07; 67 - 68

P07: I'd heard so many horror stories about it, but it got so bad that we hud tae come back in and says we're gonnæ huv tae try it, 'cause he was getting so out of hand ...

Many fathers did not want their sons to be medicated, which had an effect on their own emotions. This was described in rich detail by P01:

Extract 19: P01; 432 - 441

P01: That destroyed me that [son] had to take tablets. Initially I thought it'd be for the rest of his life and it destroyed me. I couldn't speak about it. I was on the phone to my brother. Told him and I was telling him about it and I couldn't say that [son] had to go on tablets. I couldn't speak to my brother. I was in tears and I just felt awful. I felt absolutely awful. I felt that so much guilt that the wee fella was on this. It just destroyed me, it really did. It gutted me. But eh, it's [father's brother] is looking from the outside. He's sayin' well if it's gonnæ help him it's gonnæ calm him down and it'll help you. I realised all that. I could see the bigger picture and it'd help [son]. It'd probably help us as a family cause we wouldn't constantly be on his back and wouldnae be shoutin' at him. But it didn't make me feel any better. I could see the big picture as well, but it's the fact [son]'s havin' to take these tablets for the rest of his life.

The strength of the emotional impact of feeling that he had to medicate his son can be seen in the use of the language 'it destroyed me' 'it gutted me' and 'I just felt awful'. P01 describes how his emotional reaction could not override the possible benefits that medication may allow. Indeed, the emotional reaction and dissatisfaction of having to medicate their sons typically involved emotive language:

Extract 20: P03; 232 - 233

I'm not going to have him just sitting there constantly doped up to the eyeballs

Extract 21: P08; 605

I felt I was gonnae make him susceptible to being depressed and getting down about things.

3.2.2 The ongoing dilemma of medication

However, side effects of medication were described by most fathers, and again they faced a dilemma. On the one hand the medication helped one problem, but, on the other, the side effects in another area of their son's functioning were seen. Balancing the benefits and side effects of medication was an ongoing, unresolved process. This dilemma is described by P01:

Extract 22: P01; 458 - 466

P01: He's not sleeping that great again. We'll maybe have to review the tablets again. And then again it's back to the scenario of are we dumbing him down, are we dopping [son] up to get to sleep? That's, I don't like that. But then in the same breath I don't want him up 'til 2 o'clock in the morning every night. We cannae have that either. So it's a constant juggling act. It is. We want to do what's right for [son], obviously, we want to do what's right for everybody and I don't want him to tablets, I don't want him to take any tablets, but if he's got to take them he's got to take them I realise that. But it's still sore. As a parent it's sore on you. It really is sore on you. That's just... as I say you just have to get on with it don't you really. But we can maybe have to look at his medication again as it's quite a lot.

The above excerpt exemplifies discomfort and dichotomous thoughts that many fathers experienced towards medication, as well as the "juggling act" of trying to achieve what is best for everyone. P01 also highlights the sense of a lack of control brought about by the fact that his son *has* to take medication. This was a typical description for many fathers, as highlighted in "*the first dilemma of medication*". The ongoing, unresolved process described by the majority of fathers is highlighted in the above excerpt, where P01 makes a decision that the medication can be reviewed. The dilemma of ongoing medication changes were described in most of the narratives. For many fathers there were feelings of uncertainty and unease which were represented in phrases such as 'touch wood' 'fingers crossed' and 'wait and see'. The strength of which was present on in my reflective diary (see section 4.5 for reflective diary)

Extract 23: reflective diary 16/05/08

When carrying out an interview today with P06 I was struck by the sense of hope and trust that fathers have to place in medication as they see it as their only option. P06 described side effects

that effectively changed his son's personality and he touched wood that everything was going to be alright with the new medication – I found myself touching the table too. I feel really sad for the fathers and the lack of options that they have. They have to hope that medication is going to help but side effects means that it is a horrible option.

P06 narrative that prompted the refection above described below:

Extract 24: P06; 180 - 185

P06: ... the first medication schoolwork was brilliant, so I was kinda in a dilemma, I'm going well do we keep him on that medication for his schoolwork? And we've got to see him look sad? So I'd the choice of keeping him on that, and daeing that, or else putting him on this other medication, that I felt was making him, making him I felt making him a better person. I'm saying if its going to affect his school work, I wissnae that I was saying that I don't care, but I'm going like, we will obviously just need to try and push him, and try and encourage him to, do a wee bit mare at school.

P06 describes the newer medication as making his son a “better person”, highlighting that the previous medication had a detrimental effect on his son's personality. His later description of his son also indicates this:

Extract 25: P06; 765 – 777

P06: he was dead down looking, always always, dead down looking, I was scared to look at him sometimes, cause he was so down because he was getting me down, an awe the money in the world can't change that, you know, me taking him out and buying him things is no the answer for him [lines suppressed 768 – 772] but I'm no putting him back on that medication to improve his school work, he'd be back to that wee boy he was again ...

In the above excerpt P06 describes his son as being “that wee boy” suggesting that P06 perceived the medication to have caused a negative transformation of his son's real personality into that of another boy removed from the son he knew.

3.3 Superordinate theme: perplexed parenting – parenting a son who has ADHD

All fathers described having been confused and perplexed as to why their son was behaving in a certain way, and the diagnosis was seen as giving them an explanation. Fathers then talked of having to adapt their parenting approaches to take ADHD into account. However, fathers continued to describe feeling perplexed, frustrated and lost in their parental management.

3.3.1 Shifting boundaries – what is ADHD and what is not?

As ADHD is a behavioural condition, differentiating between which behaviour is out with the 'norm', and thus related to ADHD, and which behaviour is "normal" but limit testing, was an issue that recurred across many narratives. This concept was discussed to varying degrees, but, for a many fathers it was a difficult adaptation.

The differentiation between ADHD behaviour and "normal" behaviour was a particularly salient issue for P01, and is an issue that he continues to have an ongoing struggle with:

Extract 26: P01; 54 - 60

... it's a fine line I find it a fine line it's I still struggle with it is where the ADHD starts and the bad behaviour begins, because every kid's going to have bad behaviour, every kid. But not every kid has ADHD and sometimes I find it hard to differentiate between the two and that's not failing on [son] obviously it's a failing in me, I feel, that's my failing as well, I still cannae identify when it is bad behaviour and when it is ADHD, and I know that I beat myself up about it but I don't think anybody else could be able to tell either when it's ADHD or when it's bad behaviour.

From the above excerpt we can see the guilt that P01 feels, as he internalises the blame for finding it difficult to differentiate between ADHD behaviour and "normal" behaviour. However, he also describes that he thinks that others could not do this successfully either. Indeed, across many transcripts this was a typical difficulty as exemplified by P02 below:

Extract 27: P02; 123 – 131

... tell him to do, ten lengths [swimming], breaststroke like, after three lengths [son's] lost interest, one because of the ADHD, concentration will no go any further, two, because he doesnae like it ((says this with conviction)) so its getting the combination of the two, of what part is actually losing the concentration, and which parts actually playing on it, and just like having a carry on [lines suppressed 127 – 129] because he's got the got the capability of doing the training but he's not got the eh concentration to do it but he's also no got the interest to do it...

In the above excerpt P02 describes that his son as has the capability to carry out the task but that he does not do it. This illustrates the type of attribution that was described as leading to frustration across all narratives. As we saw in "*the search for answers – guarded acceptance*", (extract 15), for P02 this was an issue that had previously caused tension at points between himself and the mother due to their differing attributions for the behaviour. The above excerpt demonstrates the ongoing daily battle for fathers to make sense of their son's behaviour in the context of

ADHD. P02 later discussed the motives behind why swimming was important to him, which highlights the possible reason for his frustration:

Extract 28: P02; 133 - 135

... once he's learned to a certain level that I know that if he goes out with his pals and falls in the water he's gonnae get out ok but until he gets to that stage I'm no gonnae let him pack it in ...

Underlying the wish to teach his son to swim seemed essentially to be a protective concern. Similar fears were commonly described by all fathers and are further discussed in "*heightened sense of parenting responsibility*".

However, when fathers described being removed from situations that involve raised emotions (i.e. where they would typically think that the behaviour was deliberately provocative), fathers seemed to find it easier to differentiate between ADHD behaviour and "normal" behaviour. P01 who felt he had particular difficulties with this, later describes as situation where he very succinctly explains to a teacher what ADHD behaviour is:

Extract 29: P01; 548 - 551

I said, he doesnae need to go to the toilet, I said that's got nothing to do with going to the toilet, he'll go there and come back in, probably not do the toilet. I says that's cause he's fidgety, it's part of ADHD. He shouts out. I said that's part of ADHD as well. Impulsive, that's all part of it. "Oh right". So they know that.

We also see from the excerpt the proactive and protective nature of the father's relationship to his child: educating the teacher allowed his son to be better understood within the context of ADHD. This was a common theme for all the fathers and is further discussed in "*heightened sense of parenting responsibility*".

3.3.2 Shifting boundaries – compromise as a result of medication

Across many of the transcripts a theme of "*compromise as a result of medication*" emerged. Fathers described the difficulty in maintaining the boundaries and structure within the household as a result of medication side effects. Side effects such feeling hungry at night were described as interfering with the routine within the house which often resulted in frustration. Across many of the narratives fathers described their son's poor sleep, and in some cases insomnia. For many of the fathers this involved

shifting sleeping arrangements such as sleeping in their parents' bed, or fathers sleeping poorly themselves when hearing their son wandering the house at night and worrying about their safety.

P03 describes how medication has interfered with his son's appetite:

Extract 30: P03; 118 - 125

P03...he'll want something to eat, and this can go on until about one, two in the morning sometimes.

I: So what impact does that have then? How does it impact on you?

P03: Crabbitness [irritable]. Will you just get to your bloody bed? You've had enough to eat. No you're not getting it anymore, or you'll get it, and it'll be right, this is your last for the night, and then he'll come back in another half an hour later wanting something else to eat or something else to drink. And we have to give in to a certain extent because he hardly eats during the day, he's so skinny.

In the above excerpt again we see frustration and irritability demonstrated by the use of language like 'get to your bloody bed'. This epitomises the frustration and irritability, that fathers described, which was commonly linked with behaviour that was disruptive and out with the normal routine within the house. P03 tries to accommodate his son's request as he notes he's 'so skinny', suggesting that, despite the knowledge that this problem is a side effect of the medication, it does not lessen the emotional and physical impact for fathers.

P01 also highlights the disruptive nature of this problem for family routine:

Extract 31: P01; 494 - 500

... I'm sittin' there and I'm shattered and wantin' to go to my bed. He's hungry so you're like that – for God almighty eat at the right times, eat at the right times. And you know it's not his fault because of the medication ... once people have had dinner, everything's put away .. then [son] will get hungry later on.

We see from the excerpt the disruption highlighted by the statement 'people have had dinner' highlighting the difference in his son's behaviour to that of the rest of the family. This highlights again the dilemma of medication. Although it improves their son's functioning to some extent the side effects impact greatly of the structure and routine of the family.

3.3.3 Fathers' active (powerless) parenting

Across many transcripts a theme of actively trying their best to parent but feeling powerless to help their sons emerged. Fathers felt lost as to how best to parent their son in the context of ADHD:

Extract 32: P03; 265 - 270

P03: ... you've still got to install in him like, stop what you're doing, think about it, behave yourself. And he does to a certain extent, but then again, he'll do it for a wee while and then he might kick off again. Other times you can go away and he'll be nice as nine pence, not cause a bit of problem. And then it goes blows up, and you go, well what caused that? Sometimes there is something that has happened that has caused him to go off on a tangent. Sometimes it's just no apparent reason but he'll come out with something silly.

P03 describes his endeavours to instil discipline, yet the behaviour continues. This illustrates the sense of powerlessness parenting that was evident across all narratives. From the above excerpt we also see the attempts of P03 in looking for antecedents to his son's behaviour, a sense of bewilderment at his son's 'reasonless' behaviour. Fathers, who were typically perplexed, were lost as to how to parent their son, which linked to feelings of powerlessness. This was a theme strongly evident in P07 narrative. Perhaps here powerlessness was compounded by the level of his son's aggressive behaviour and, as P07 noted an "older school" parenting style (extract 61):

Extract 33: P07; 27 - 29

P07: ... he punched her [mother] so hard he put her on the floor, but, within seconds you could go out the back door and come back in and it's forgotten, and he'd have a normal conversation as if it hadnae happened ...

Extract 34: P07; 313 - 317

P07: ... how do you control him, how do you show him right from wrong, when you shout at him, he'll shout back, shout louder back, you know he's got to get the last word, if you ignore it he thinks he's won, he thinks this is the way it is, and if you don't ignore it, he'll sit and argue all night...

P07 appears utterly bewildered and powerless to manage his son's behaviour. Although not all fathers described the same level of oppositional behaviour toward themselves as parents, the sense of powerlessness and feeling lost emerged across most the transcripts. This suggests that ADHD leaves fathers feeling low levels of control as parents, and this perhaps relates to feelings of poor parenting competence.

3.3.4 Fathers' active (frustrated) parenting

All fathers described the frustration they felt in parenting their son and the implications for how they saw themselves as parents. Fathers' frustration was linked to constant disruptive or active behaviour and repeated attempts to try and "get through to" (P04; 24) their son.

In the following selection of narrative excerpts we follow P03. Here we can see how he expresses feeling frustrated as a result of his son's relentless behaviour, his reaction to the relentless behaviour, and his mixed emotions in response:

Extract 35: P03; 286 – 291

P03: He wears you down. He, constant, can I, can I, can I, can I, can I, can I, can I, can I, can I. I mean he, he loves biscuits. So we've got the biscuit tin and that and he'll just constantly be at you for one after another, after another. And it's just he wears you down, with the saying can I get, can I get, can I do, can I do, and when it's been like this for an hour you get to the stage where you go right, enough, shut up, get on the stairs ["naughty step"].

P03 later describes surrendering to his son out of sheer desperation and exhaustion:

Extract 36: P03; 307 - 309

P03: ... I'll admit it, I've gave into him many a time, because when he, somebody's constantly in your face like that for two hours in a row when his mum's at work and if he's if he's can I get, can I get...

In the above excerpt P03 possibly felt uncomfortable discussing his son as being a problem or a difficult child. He corrects himself by stating 'he', but he then changes this to a vague 'somebody's'. This distancing and protective stance was a common theme for fathers, and is further discussed in '*heightened sense of parenting responsibility – defending son's character*'. The above excerpt perhaps highlights the difficulties in maintaining a consistent approach in parenting a son who has ADHD. P03 describes 'giving in' whilst his partner was at work, suggesting that, as joint parents, they are attempting to manage his behaviour in a particular way.

P03 describes his mixed emotions after he has given his son what he wanted:

Extract 37: P03; 323 - 326

I: And so afterwards if you've given in, like you said, how does it feel afterwards?

P03: Em, frustrating because basically giving in to him for doing .. other times it's just a God send just to say right that's it, a shoot of lightening, I've got peace for what, ten minutes, quarter of an hour?

The impact of his son's behaviour can be seen where he describes the relief as being a 'God send' and a 'shoot of lightening'. This highlights the level of stress, mixed emotions and frustration that many fathers feel in response to constant unmanageable behaviour.

All fathers described frustration which was often a result of their son's inattentiveness and feeling that they could not communicate with their son. Frustration related to having to constantly prompt their sons in tasks. Homework was described in some narratives as a particular source of frustration and was described as a 'battle' (P05; 211) and 'he needs three or four times, the time with him [as the other children]' (P08; 403 – 405). In the following excerpt P04 describes his frustration whilst assisting his son in completing his homework:

Extract 38: P04; 357 - 367

... when he went on the medication you could see that he was trying a wee bit harder and he would still kid you on that he couldn't do it and some of the homework should only take about half an hour and you would be there for about two hours [lines suppressed 359 – 360] you would still get kind of annoyed, come on you're at it, this is just half an hours worth of work [lines suppressed 361 – 362] ... you could feel yourself starting to get onto him again ...

Extract 39: P04; 474 - 475

... you kind of felt that you had been a bad dad kind of thing because you're getting onto him all the time ...

In the above excerpt we see the frustration and the beginnings of an argument. The language used suggests that he sees his son's behaviour as being intentional: 'you're at it'; 'kid you on that he couldn't do it'. This example again typifies a common difficulty for fathers in gauging and attributing what behaviour is a result of the child's ADHD or intentionally not wanting to complete the task and the emotional impact on fathers.

3.4 Superordinate theme: the battle to balance family life

As we saw in "*perplexed parenting - parenting a son who has ADHD*", fathers often expressed struggling to manage their son's behaviour. However, this process does not occur in isolation. The majority of fathers had other children and wives or partners, all of whom are affected by the son's behaviour to varying degrees. In a sense, the

stability of the family equilibrium becomes unbalanced through ADHD. In the next section the fathers' *battle* to maintain a family balance is described.

3.4.1 Striving to keep a balance with the other kids

All fathers (with the exception of P07) had other children living in the house. They describe a challenge in balancing care and attention for their sons with ADHD and their other children. They also describe striving to parent all the children "the same" and treat their sons as "normal". However, difficulties arose for a number of reasons which will be discussed below.

The difficulty in balancing attention and care for his son who has ADHD and his other children was particularly well described by P08. This was an especially pertinent issue for P08, as he has three other children, all of whom are younger than this son. The following group of excerpts highlight his attempts to maintain the family equilibrium.

In the excerpt below we see him describing his initial intentions not to treat his son differently to his other children:

Extract 40: P08; 318 - 322

... I had said to myself after ... he had been diagnosed as having it that I, I was gonnae try my best no to make him different from the rest of the kids, or, no to try and do it in a sneaky way, but for to try and deal with him differently, but try and make him feel the same, cause I think eh, the, the thing for him is that he does just want to fit in and that he doesnae really want to be different from everybody else, but he cannae help the way that this eh disorder that he has makes him react ...

In the above excerpt we see P08 making a conscious decision to treat his son's condition in a covert manner, in order to protect his son's feelings. However, this characterises the problem for all fathers: ADHD can not be hidden from siblings, as the behaviour is visible to others and so does impact on the family unit. It also highlights the dilemma for fathers of recognising this while not wanting to *highlight* to the siblings that their brother is 'different'.

The level of impact on the siblings as a result of caring for their sons was described to varying levels. P08 despondently reports that it has a big impact on his other children:

Extract 42: P08; 20 - 23

I don't like to say it's difficult with [son] but it is, y'know the whole family has to revolve around us .. caring for him in a different way from how we care about all the other kids. I mean it's cruel to say that they suffer in their attentions through the fact that he has to have so much from me and [mother] ...

P08 appears uncomfortable discussing the idea that his son's condition has an impact on the care for his other children. We see this in his use of the word "cruel". Again the protective stance that fathers adopted is relevant here as he does not want state that his son causes *difficulties*, but eventually concedes that he does. This demonstrates the guilt and dilemma for fathers. Whilst they do not want any of their children to feel 'left out' or less loved, the child with ADHD requires more time and parental management than the other children. The element of guilt in the imbalance of care is later highlighted where he discusses thinking about his son when he is at work:

Extract 43: P08; 776 - 773

P08: I do, I suppose it's selfish of me, but I do think about him quite a lot in work y'know I, I just worry...

I: Selfish? In what way? What do you mean?

P08: Cause I'm no thinking about the other kids. I feel that I'm no distributing my, my thoughts for them in a fair manner, although they're no aware eh .. I didnae feel like I'm, like I'm diddling [cheating] them out of my feelings or my thoughts, but I just feel sometimes that they're, that they miss out cause I didnae get to think of them because of the situations that'll arise through [son] ...

In the moving excerpt above there is a sense that there is not enough love and attention to go round. It highlights the extent of his concern that his love and attention is not equally distributed. He tries the best that he can for his children, but feels guilt that, not only his actions are not equally distributed, but his thoughts are not either. Again this illustrates the difficulty for fathers in where there is a child who has ADHD who is perceived to be needier than others

The battle to maintain family equilibrium was played out in a number of complex ways. A common theme across some transcripts was the imbalance in the family due to conflict amongst siblings as P05 describes:

Extract 44: P05; 272 - 277

... they [daughters] know that he has the problem, em, I think sometimes they feel he gets favoured a bit, em which isn't true, like they are typical teenagers, the world's against them ... sometimes you have to remind them .. that .. [son] behaves differently from people and em they

just sometimes they just they're not interested in that, that argument, they just couldn't care less about that ...

In the above excerpt there is a sense of feeling accused that he favours his son. It highlights the difficulty for fathers managing their other children in the context of ADHD. They seem to be trying to *prove* or make their other children understand that they are *trying* to be fair, but feel that siblings can have difficulties accepting this.

P05 later described a typical scenario where the balance is disrupted:

Extract 45: P05; 286 - 291

... he'll have a drink of his juice and he'll break wind or something, and the girls just go apoplectic about it, em that can cause difficulties, 'cause obviously your just in from your work and your just sitting at your dinner you want to have a bit of peace and quiet or talk to the kids and find out what kinda day they've had and then [son] does something like that, everybody's in an uproar ...

In the above excerpt we see the scale of the disruption in the use of the language "apoplectic" and "uproar". It also highlights the difficulties for fathers in their adjustment of expectations. While they wish for 'peace and quiet' or 'normality', the disruption leads to a quite different view of their perhaps idealised vision of family life.

A trend for fathers seeing themselves as 'peace keepers' or resolving sibling quarrels emerged, but again the difficulties reflected earlier in maintaining a balance with all the children was highlighted. In the excerpt below P02 describes this:

Extract 46: P02; 307 - 309

... if he did start going temper started going towards his brothers or brother or sister or that try to obviously intervene for to stop it that kinda thing ...

Extract 47: P02; 339 - 348

... I'll maybe go up [to sons' bedroom] and play with him for a wee while or that, that kinda thing for to try and get him to come out of his mood or kinda to try and keep him away. But because you've got three kids its very difficult to do ... the youngest one wanted to come with ye, which puts you in exactly the same position that you were in before, you try to take him away because, it was the wee brother that was getting his temper up, for whatever reason, and its like, no, it's to turn round and say no, you cannae come and play here, you're excluding him [other son], its just ((laughs)) you're stuck in a wee centre there, I don't which way to turn!

The above narrative illustrates the dilemma of trying to manage their son's emotions, while trying practical solutions such as removing him from the situation. This is often not practicable, again leaving fathers feeling 'lost' as to what to do.

Conflict or "sibling quarrels" *do* occur in families who do not have a child who has ADHD. However, the particular struggle for these parents seems to be in differentiating between whether the behaviour that they see between siblings is 'normal' or related to ADHD. This was commented on by P05 and P01:

Extract 48: P05; 265 - 268

You have normal sibling quarrels and then with the way [son] behaves, eh the girls can get quite angry with him, it can end up quite a shouting match, doors slamming, but I suppose eh a lot of people would say that about their kids, and they wouldn't have ADHD ...

Extract 49: P01; 323 – 325

... "You [son] cannae stay home with your brother 'cause you fight". As soon as we shut that door the two of them would be at it. It's just, same again is that brothers being brothers or is that the ADHD kicking in again?

3.4.2 Maintaining a balance with mothers

Across most narratives a theme of *maintaining the balance with the mothers* emerged. From the initial stages of diagnosis through adapting to the diagnosis, fathers described working through disagreements related to their son. There was a sense of readjustment, compromise and a move toward joint parenting across the narratives.

Disagreement over their son's management was seen across some of the narratives.

P02 describes this below:

Extract 50: P02: 251 - 256

I: If you weren't doing what right?

P02: You know if I didnae handle it correctly or if I blew off on one as I would put it, lose the temper, [son's] classed as ADHD, [partner] turn and say "That's no gonnae make any difference to him – you need to do it this way". Of course me being me, I'll take that as being like an insult, your telling me how to, then of course, a wee bit of an argument, I think this is probably just normal for, I mean now, it's, no nothing like that now, that was just in the early days ...

Here, P02 describes how differing opinions between him and his wife about management lead to arguments and unbalancing of the relationship. As we previously saw from extract 15, P02 avoided learning about ADHD as he had difficulties

accepting the diagnosis. This highlights the difficulty where a parent is not ready to accept a diagnosis, as it impacts on consistent parenting. P02 makes a distinction between the “early days”. This suggests that through time there was a progression towards a more balanced, joint approach to parenting. He states it is “probably normal”. Indeed across the narratives this did emerge. The impact of the differing parenting styles in the “early days” was also described by P04:

Extract 51: P04; 206 - 217

... I felt I we just weren't getting anywhere, then [mother] was getting on at me because I was getting on at [son] for not doing stuff, “Will you leave him alone? He'll get round to it when he's ready” And it's like, no, you shouldn't have to ask him five or six times, and then I'm not saying we fell out, but it was, you felt, there was an atmosphere ... [lines suppressed 210 – 214]
... We didn't get to the point to where we didn't speak to each other for a week or anything like it, just you could feel yourself getting snappy because she felt I was treating him unfairly if you like because I was asking him to do stuff and he wasn't doing it ...

In the above excerpt P04 refers to how he felt frustrated and irritated that his son would not adhere to his continued requests to do a task. This again highlights the sense of frustration highlighted in the theme “*fathers' active (frustrated) parenting*”. In a sense, the pattern seems to be for the mothers to defend their children (“he'll get round to it”), where the fathers seem more inclined to challenge and enforce limits, leading to a split between parental roles. P04 also refers to feeling that they were not “getting anywhere” in reference to his favouring of medication at an earlier stage when compared to the mother. Again, the difference of opinion relating to the medication decision emerged across some of the narratives.

P05 describes the differing opinions and the process of the medication decision:

Extract 52: P05; 232 - 233

I: What about, I was just thinking there about, how your experience has compared to your wife's, in terms of diagnosis and when you were thinking about the medication?

P05: Em .. I would say my wife was keener on the medication than I was

I: And what happened?

P05: Em there wasn't much of a conflict between us if that's what you mean, I don't, there was nothing, we spoke about it, eh but obviously like I said my wife was on to this before I was, she was really keen to see something done, I was a bit more sceptical, especially after looking at the stuff on the internet.. em.. I think at that time I was quite happy to go along with, with what was happening, em.. obviously as time goes by you learn a bit more about it, but I mean we hadnae, I mean, she was right in you know wanting to push on, and get something done, and I think, eventually I got behind that em, but there wasn't any major conflict between us ...

Here, there is a sense of resented cooperation, suggesting that perhaps medication was a contentious topic between the couple (“sceptical”, “hesitant”). There then seems to be a move toward a joint approach (“eventually I got behind that”). Although the topic of “conflict” was not introduced in the question, perhaps there is an element of defence as he says: “there wasn’t much of a conflict between us if that’s what you mean”. Interestingly throughout the narrative of P05 there was a theme of ‘moving on’ (see section “*managing uncomfortable feelings - moving on*”) and reluctance to discuss medication. This highlights the difficulties for families who have to make the decision related to the uptake of medication. Perhaps the controversy and split opinions in the media and in the research literature are played out in the parents’ decision making it a highly emotive topic.

3.5 Superordinate theme: heightened sense of parenting responsibility

Throughout all the narratives a theme of *heightened parenting responsibility* emerged. This was played out in a number of ways during the narratives, and seemed to be based in underlying fears and concerns for their sons. It appeared that fathers battled to counteract the realisation of fears by being pre-emptive, proactive and by having a heightened sense of protection for their sons.

3.5.1 Trying to protect son’s future

Across all narratives fathers were fearful of the link between ADHD and future criminal activity as P08 describes:

Extract 54: P08; 478 - 483

That’s one thing that I do make sure that he’s, that we say to him, if you’re no gonnae go to that [sports club] you need to find something else to do, cause the last thing we want him doing is hinging about the streets or hinging about the shops. Eh, or getting into bother or that, I mean no, cause, I mean, it’s proven wi him having the condition he’s got that he’s susceptible for eh, a criminal life or a drug life, it’s one of our big fears for him y’know and that’s one of things we try and keep him active about.

Here, there appears to be a proactive and pre-emptive stance as a defence against a hypothesised catastrophic future. This was typified across all the narratives, and highlights the huge anxiety that fathers fear. Pre-empting issues at an early stage as

means of protecting their sons was a common experience described in all the transcripts, this also extended to the school as P01 describes:

Extract 55: P01; 590 - 599

... they [school] quickly labelled [son] a bad boy. [lines suppressed 590 – 591] he got labelled right away, didnae want to know. Schoolwork was dreadful, reading a nightmare, wouldnae do homework [lines suppressed 593 – 595] at the beginning all we got was negative feedback. And we're going, aye, he's this, he's been diagnosed with ADHD, aye he's got problems but he's no as bad as they're thinking. This cannae be right ... I went no way, I said I'm sticking up for him and I went in and set up the meeting.

In the above excerpt we see P01 defending his son by proactively arranging a meeting to advocate for his son. Dissonance in the perception of his son between the school and P01 is illustrated by the sentence “he's no as bad as they're thinking”. Indeed, across the majority of transcripts fathers appeared to be acutely aware of negative judgement of their sons which resonated in most of the narratives.

3.5.2 Defending son's character

As described above the dissonance between the fathers' perceptions of who their son is and the sons' public character – which often ranged from being seen as ‘mischievous’, a ‘bad boy’ or perhaps just different – was an issue that fathers appeared sensitive to. Fathers had an internalised dichotomy of the two sides to their son's character, on the one hand their son, and on the other a difficult child. However, in external situations fathers adopted a protective stance to guard against what they anticipate are other people's negative judgements of their children.

In the excerpt below P03 describes the complexity of protecting his son from other people's judgements when they are in public:

Extract 56: P03; 356 - 362

... [In the cinema] you could hear him [son] squeal, and, shout, and everything like that, and you'd see the occasional person turn round, going “Interrupting my film here!” ((laughs)). Tough. You know? Go and see the manager if yer no happy. Know what I mean?

I: How does that make you feel?

P03: To be truthful, I'm no bothered about what anybody does, as long as ma boy's happy, em, they can moan and they can shout they can do whatever they want. If they want tae start a fight, so be it, it's on their own head ...

In the above excerpt we see a heightened sense of protective feelings demonstrated in the strength of his actions to consider physically fighting others in order to defend his son. This also highlights the quandary for fathers in defending their son, and possibly their parenting skills, where their son's actions are often visible and therefore judged as inappropriate, or their parenting skills judged as poor.

In the narrative of P02 he appears to protect his son in the interview:

Extract 57: P02; 363 - 365

... that's when you had to intervene and get [brother] out the road and just say like "[Son] calm yer sel doon, relax, watch the telly, do something, just calm yer sel doon"... he has never been a boy for striking out, in any way shape or form, I mean like I says, he's a big soft natured laddie and he's .. he's had, out of the three of them [other children] he's the only one that, you know, would give ye his last Rolo ((laughs))

In the above extract P02 describes his son's problematic behaviour, but then immediately defends his son's character and emphasises his qualities. This protective stance in the interview occurred across most of the narratives. The fathers appeared to struggle to depict or express that their sons are a 'problem'. It is possible to hypothesise that the struggle to describe their sons as being 'a problem' suggests that fathers feel they are agreeing with the anticipated judgement by others, and, in this sense, not protecting or accepting them, as a father 'should'.

3.5.3 Fathers' absorbing son's responsibility

Fathers heightened sense of responsibility also involves in a sense absorbing their son's responsibility for their own safety, as they have not yet developed self control or judgement of consequences. Throughout all the transcripts fathers highlighted the difficult balance of 'letting go' and transferring responsibility to their sons and protecting them. Constant vigilance and a ubiquitous sense of responsibility emerged across all transcripts.

Extract 58: P04; 452 - 460

... I feel you kind of hold him back because you just can't trust him to go and do something. [line suppressed 453] we've let him take the dog past the corner that we normally go to because he would probably would just go and wander away off [lines suppressed 454] he would just kind of want to do his own wee thing or maybe he would go and speak to some of his pals or worse still the concern is he goes away for a walk and then somebody comes along stops the car, speaks to him, and then he goes away in the car with him, you've still got that kind of, you can't trust him to take the right decision on that ...

In the above extract we can see an expression of fear underlying the hesitation to transfer responsibility to his son in a task and the diminutive progression in the transfer of responsibility. This extract typifies the sense heightened sense of responsibility for their son's safety across all the transcripts.

Some fathers described making various attempts to transfer some responsibility to their child however; they often lack confidence that they can cope with it:

Extract 59: P06; 289 - 297

I keep saying, you only have to come and tell us, that's the only thing, I keep saying "you need to let us know where you are!" If [son], I think he's the type of wee boy, he forgets me telling him that, and then I say "Does he forget me telling him that?" But he probably, I don't think he forgets, he probably just goes "Uch, it'll no matter, it'll be alright" You know? But he doesn't understand the danger, we would like to know where he is, because of, the weirdo's going about eh, you never know at the minute! Trying to drum that into him, just, "It only takes you two seconds wee man, to come in and say – dad, I'm going here, mum, I'm going there" Just so we know where you are. "I know, I know" But see, if he was away to where he's going, before he realises, "I'll tell my ma, I'll tell my dad, and I've no done it, uch, it'll no matter" He'll no come back.

In the above extract it appears that P06 feels that forcing repetition ("drum that into him") is needed to pass the sense of responsibility over to his son. This epitomises the continuous attempt to teach responsibility and is closely linked with the previous theme "*fathers' active (frustrated) parenting*". In the above extract we see P06 questioning whether his son "forgets" an instruction or if he actively ignores it. This illustrates the sense of uncertainty as to whether responsibility can be given and perhaps this sense of uneasiness serves to maintain the heightened sense of responsibility.

In some transcripts a sense of cautious optimism for future responsibility emerged:

Extract 60: P01; 74 – 87

P01: Obviously if you've got ADHD you are going to have it for life – I think he's going to manage it better.

I: What way do you think you manage it better once you get older?

P01: The likes of stranger danger things like that, and being careless. [lines suppressed 78 – 80] ... we don't let [son] anywhere near it [canal] obviously, cause [son] would be one of those guys who'd want to see if he could jump the canal. Now when he's older, he'll be able to realise "I cannae jump that canal – I cannae try" [lines suppressed 83 – 84] he'll he'll he'll get to realise "no I cannae do that, that's dangerous." At the moment he's no at that stage, and that comes with maturity. I think it comes later in life, with somebody with ADHD because you cannae see it, whatever part of the brain's shut off to that is still shut at the moment, so he doesn't see danger, where you would see danger. He would just go "ah that would be a great laugh" but

that'll come with maturity with [son] and I think it does with a lot of kids with ADHD. So hopefully ((laughs)) touch wood.

Interestingly for P01, whose scepticism of ADHD was highlighted in excerpt three, we see him here describing that his son's lack of control is due to neurological reasons, as he makes relevant the medical model of ADHD ("part of the brain's shut off"). This possibly highlights that, even in cases of scepticism about ADHD, its reality as a medical condition is accepted on some level. This may also be seen as contributing to the maintenance of the fathers' heightened sense of responsibility, as ADHD is viewed as something that they and their sons have no control over. However, the tone of uncertainty is illustrated by the term 'hopefully touch wood'.

However, the cautious optimism that their sons would develop responsibility was not shared by all the fathers and in particular P07. P07 describes the heightened sense of responsibility that is ever-present to the extent that he worries about his son's well-being after his own death:

Extract 61: P07; 307 – 318

Its really, really hard for somebody my age, older school, you've had a normal life and all of a sudden this thing comes into your life, thinking that I've got my son, I was so proud when he was born, I've got my wee boy now, all through life he gets worse and worse and worse and worse, and then all I've got is what's in the future for him now, cause, I'm probably not gonnae be here when he leaves the school, it's whose gonnae guide him? Especially if he is the way he is the now, if he's gonnae get any worse, its worrying for myself, is he, the stories I've heard about the drugs, is this what he's on [medication] is it gonnae put him on that road? I'm no gonnae be there to guide him. You try and do the best you can the now to try and put him on the right road, but, its its no.. his behaviours no the best the now, I can only see it getting worse, if we cannae get something sorted .. I'm no happy about him being on drugs [medication] but, there's nobody call tell us any alternative, we don't know where to turn ...

The above excerpt is a particularly poignant description of how P07 envisions the future for his son. He was an exception in that he was much older than the other fathers' thus perhaps thinking about his death was more relevant for P07 than the other fathers. He describes the feeling of almost losing his (idealised) son throughout his life, and experiencing the future with a sense of foreboding. There is a sense of time running out and the fear that he can not leave his son with no guidance. P07 also appears to have made a link between medication for ADHD and probability of future illicit drug use.

Extract 62: P07; 319 – 325

I: So you were mentioning the future there, and em, the sort of worry about, drugs and the kind of road that's ..

P07: I mean we're surrounded by drugs, the street, there's sellers every second door, their all sellers, drug users, I mean he sees what's going on, he sees it happening, and if I'm no gonnae be here .. I can feel myself getting older, I've had a heart attack, I've got aches and pains, I really feel myself, I can hardly walk from work at night, the knees are sore, the backs sore, so I feel myself .. going downhill ...

From the above emotive excerpt we see that P07 feels that his health is failing and his ability to protect his son is also diminishing. A fear that their sons could be involved in criminal activity was reflected throughout all the transcripts. However, for P07 it appears to be more than a hypothesised catastrophic future and closer to reality than the other fathers, due to social circumstance and weakening protection.

3.6 Superordinate theme: managing uncomfortable emotions

As we have seen throughout the analysis, fathers describe a wide variety of emotions throughout the diagnostic process and beyond, ranging from anger, fear, frustration and irritability, to powerlessness, hopelessness and sadness. In this section the hypothesised psychological processes that fathers intentionally or unintentionally use to manage these emotions will be highlighted.

3.6.1 Comparison

For the majority of fathers, once the diagnosis was made they compared themselves to others who they perceived were worse off. Some fathers also reappraised the situation by comparing it to a hypothetical worse case scenario: "*it could have been worse*". This appeared to serve as an adjustment strategy that allowed them to look at the situation from another perspective and, in turn, reduce uncomfortable emotions. The notable exception in this sub-theme is P07, possible reasons for which will be discussed in due course.

For P06 this comparison began during the appointment where he learned of the diagnosis:

Extract 63: P06; 125 - 129

... in a way when I found out, on what level that [son] had it I was quite relieved, because it wissnae as serious as some other kids, that's what [clinician] was saying to us as well, you know he says "I'm no saying its no a problem, it is a problem" But, he says, but on he says on [son's] level he says, and he told us all the ways it affected him, and I went, uch well I can live wi that!

Extract 64: P06; 406 - 408

... we [mother and father] basically just spoke about it, we came out of here [child department], and, spoke about it and went, ((exhales breath)) "At the end of the day its no as bad as, what, what it could have been, at least we know now"...

In the above excerpt we see that P06 believes that his son's ADHD is not 'as serious' as other children who have ADHD, following the information given by the clinician. This distinction between different levels of severity, or types of ADHD was a common feature amongst the fathers' accounts, and is further discussed below. We also see in the second excerpt that, following the meeting with the clinician, P06 discussed with the mother that the diagnosis was not the worst case scenario.

To explain the context of following extracts it is important to note that a number of fathers had attended (part of, or all of) a parenting group⁶. Whilst at this group a number of fathers compared their son's condition to other parents' descriptions of their children:

Extract 65: P02; 202 - 205

... listening to other parents they've got kids that are kicking doors and fighting with folk and aw this kinda stuff having real trouble with them and that, I mean [son's] nothing like that, so I have a tendency to look .. .how could you put it .. [son's] lower scale ADHD, whereas the concentration is the problem ...

Again in the above excerpt we see P02 making a downward social comparison with families who have 'real' problems. We see P02 acknowledging that his son *does have problems*, but again we see the distinction between the types or level of severity of ADHD. In the next excerpt we see P02 later describing the strength of relief that his situation and his son's difficulties are not at the same level as others, and his respect for families who are worse off:

Extract 66: P02; 577 - 584

... thank God I've no got that kinda thing for to deal wi, its bad enough with what we've got the now if you would like, kinda with the concentration, getting him to work on that, but to have to deal with that as well, to deal with the two of them [concentration problems and oppositional behaviour] that's actually horrendous, so eh hats off to them.

⁶ For a description of the parenting group see section 'characterisation of the service' 2.2.2

In the next excerpt we see P04 engaging in a similar process of comparison:

Extract 67: P04; 654 - 659

I think we manage quite well, at the workshop ['Parents Inc'] you hear some of the stories about kids [line 655 – 666 suppressed] there was one woman she says she cannae take him shopping cause he used to run away from her in the shop, and she would go to find him and he would be lying in one of the freezers. And [son's] no done anything as bad as that, he's done, various bits and pieces, but he's never done anything like that.

In the excerpt below P05 engages in the process of comparison, in this case he describes ADHD as not being as bad as another illness.

Extract 68: P05; 327 - 329

I mean obviously these things can be treated, I mean there's people a lot worse off with their children than I am, I mean like kids with leukaemia or something like that, that would have been a disaster, but no no no ADHD, we have been through a few things with [son]...

In the excerpt above we see P05 focussing on the 'treatability' of ADHD as the redeeming characteristic, as opposed to a life threatening or terminal illness. P05 also describes having been through 'a few things' with his son. This is in reference to febrile convulsions that his son had suffered as a child. This is an important point to make as it is possible that this comparison to a prior worse off experience also functions as a coping mechanism.

As noted above, using comparison as a means of coping was not present in the narrative of P07. As previously discussed, P07 described his son as being aggressive and of having assaulted his mother and himself. Throughout his narrative there is a sense of foreboding and a sense of things getting worse as discussed in "*heightened sense of parenting responsibility* (extract 61). It is also possible that P07 is experiencing living with 'the worse case scenario' that the other fathers described. In the next excerpt we see P07's own admission that he finds it difficult to cope and that he *does* draw comparisons. However, they are negative comparisons and relate to loss:

Extract 69: P07; 121 - 128

P07: ... you cannae talk him out of it cause, he's, he's on a high .. he would argue black was white, everybody is wrong but [son]

I: and how's that for you?

P07: frustrating, I get very very angry, coz I was brought up with my dad, wi' no mother, my mum died when I was a baby and I was brought up by my dad, and we had a very close relationship with my dad, and my first marriage my two daughters grew up as normal wee girls,

then all of a sudden we've got this wee monster, and its, I'm I'm taking it hard, it's hard to cope
...

In the above excerpt we see the utter loss and tremendous difficulties that P07 has in coping with his situation. He compares his son to a 'monster', and compares his current situation to his own experience of being fathered in a 'close relationship' and previously being a father where his other children were 'normal'. Therefore the style of his comparison is comparing his current negative situation to previous positive situation.

3.6.2 Moving on

A number of fathers described not focussing on negative aspects, 'getting on with it' and moving forward, as another possible mechanism for coping with uncomfortable feelings.

There was a sense of huge guilt in P01 that his son had 'inherited' ADHD from him:

Extract 70:P01; 29 - 31

I must have had it because I was aggressive, I was fighting, everything [son] had, I absolutely, everything [son] had I would probably say I was worse then [son], but then there wissnae this label for whatever they call it ADHD – you were just a bad boy.

Extract 71: P01; 34 - 35

I've a lot of guilt about it I've passed something onto my son and he's struggling with it because he did struggle with it and he still struggles throughout the day ...

In the above excerpts P01 draws comparisons between his son's behaviour and his own during his childhood. Interestingly, we see a sense of injustice that his son has been 'labelled' as having a condition that was not medicalised – and thus perceived to be within the 'normal' spectrum of behaviour for a boy, despite being that of a 'bad boy'. We also see the ongoing, everyday guilt that he feels for his son difficulties, as it is evident in the repetition of the word 'struggle'. However, P01 later in the narrative describes that he can not dwell on this and has no option but to 'get on with it':

Extract 72:P01; 293 - 299

... if I thought about [son] having that [ADHD] all the time I'd be sitting there in the corner greeting [crying]... Eh, I couldnae, I'm not saying I wouldn't be able to function but I'd have a constant lump in my throat and I cannae have that. I cannae have, that just for my own well-

being ... It's not all about me. You've got family, you've got work commitments, [the mother's] got health issues, my older son's now got health issues, you cannae let it control or dominate the whole family. Not that I've ever said that, as I say, we've never sat down and had a plan, a strategy, we've never done that. We've just got on with it. Maybe that's a way of coping, I don't know. But we've never .. emotionally, no I cannae, I don't, it's no good. I probably got more emotional in here talking about it the day than I would in a long time. I've got a wee bit of a lump in my throat the now cause I'm thinking about [son] with his ADHD but you cannae let it run over you, you know, you cannae let it do that to you. There's a lot of people in a lot worse places than I am, a lot.

In the above excerpt we see a sense of self-sacrifice where P01 puts his family responsibilities as a priority. We see a description of 'getting on with it' and not thinking about his son having ADHD – a possible unintentional defence of his emotions. He feels that he *has to* get on with it as he fears that he could be overwhelmed by emotions and be 'run over' by them. This fear of being overwhelmed by emotion is immediately played out in the interview where he describes having a lump in his throat but the emotion is quickly deflected by the use of comparison (as described earlier).

The sense of moving on and not focussing on the negatives is described by other fathers. This is described below by P08 and P05 in response to their son's behaviour:

Extract 73: P08; 677 - 680

P08: ... once it's [disciplining son] done it's done and we try to just kinda draw the line and move forward from it so's that eh .. so we can remain positive about it as opposed to thinking back to all the negative. Eh...I dunno, it's the only way that we can deal with it and things, y'know it really is, it really is...

Extract 74: P05; 303 - 305

... I wouldn't make a mountain out of a molehill, you know you just, you just shrug your shoulders or you you you .. you give them a row .. you know you move on .. I don't dwell on any of these kinda things ...

In the above excerpt we see P08 and P05 'moving on' and not ruminating or dwelling on negative aspects of their relationship with their sons.

P05 describes not 'making a mountain out of a molehill'. This is a pertinent point for P05 as it relates to a theme of normalising. In the majority of the transcripts instances of normalisation of the sons' behaviour were present to varying degrees. However, it was a particularly important feature of P05's narrative. Normalising is a possible means of coping with uncomfortable feelings, and, in the excerpt below, it

may relate to coping with the side effects that medication may be having on his son's appetite:

Extract 75: P05; 501 - 505

... he's really quite thin, I mean he's like a rickle of bones sometimes, that's nearly, it doesn't it doesn't stop him, you know it doesn't affect him, he's quite a physical child, he loves, em cycling and wrestling with his friends, not violent ken, just you know, horseplay, you know what boys are like, quite a normal that way I think.

Extract 76: P05; 194 - 196

I *think* there's a possibility that it could still be affecting his appetite, its small, but em, he's he's happy enough, he's a normal, boisterous, energetic, young boy, who likes to be out with his friends ...

Again in the above excerpts we see P05 possibly coping with uncomfortable feeling by normalising, which is in a sense of 'moving on' and avoiding a negative focus.

To conclude, the analysis' results have uncovered and unpacked a series of important experiences, meanings and feelings that fathers go through when dealing and managing a son's ADHD. This has covered diverse issues raised by their experience of a diagnosis of ADHD, the management of difficult behaviours, their impact on both their relationship with their son and the rest of the family unit, and the feelings enmeshed in all these processes. The next session will now discuss the relevance of these findings in relation to the background of relevant literature.

4. DISCUSSION

4.1. Discussion of themes

This section will discuss the findings in relation to existing literature. This will make interpretative links between the ‘what it is like’ (as discussed in the results) and ‘what it means’.

4.1.1. The search for answers

Most fathers had awareness that something was not ‘right’ however, the attributions for their sons behaviour varied. Around half of the fathers on this study had questioned their competence as a parent and blamed themselves for their son’s behaviour (e.g. extract 1). This is consistent with previous literature on mothers of children who have ADHD (Harborne *et al.*, 2004). Harborne *et al.* (2004) also found that the mother’s self blame dissipated once the diagnosis was received as the diagnosis confirmed their suspicions that the reason was biological in nature. However, for some fathers in this study this was not the case. Some fathers then blamed themselves as the condition was biological, and they worried that ADHD had been inherited from them (extract 2, 70 and 71). These are important findings as in studies of mothers who have children who have ADHD, feelings of poor competence in parenting, self-blame, and depression are associated with a higher level of stress than parents of normal children (Mash & Johnston, 1983). Interestingly in the qualitative study by Harborne *et al.* (2004), mothers were found to also blame the fathers for their son’s difficulties. In this study mother blame did not emerge. In the study by Harborne *et al.* (2004) there was a theme of mother blame that related to feeling blamed by professionals and family members for their sons behaviour, however, father-blame related to the social context family members or professionals did not emerge in this study, perhaps related to mothers being the main care givers in the study.

The other fathers in the study had considered their sons to be typical, boisterous, mischievous boys. Indeed fathers normalising their sons behaviour was consistent with the qualitative study by Singh (2003) of fathers, as discussed in the introduction

(see section 1.3). This suggests that some fathers may have differing attributional styles from mothers. Possible reasons for this may be less time spent with son due to work as therefore mothers having a more knowledge of the extent of their son's behavioural difficulties, as highlighted by P05 (extract 8).

The differing stages that the fathers were at in their belief that help needed to be sought may fit with Prochaska and DiClemente's (1984) Stages of Change Model. Half of the fathers were perhaps at the *pre-contemplative* stage: those who normalised their sons as being typical, boisterous, mischievous boy. The other half were perhaps at the *contemplative* stage: those who had questioned their skills as a parent. However, the mothers seemed to have arrived at the *action* stage before the fathers, initiated the diagnosis and therefore were more active in the diagnostic process with the clinicians. The implications for the fathers at the pre-contemplative stage was that the journey to diagnosis was uncomfortable and accompanied by difficulties accepting and adjusting to what can be understood as a medical condition for behaviour that they had otherwise attributed as 'typical boy' behaviour.

A theme of fathers being observers and in some cases removed from the diagnostic process emerged. This is consistent with clinical and research practice and has been discussed in the literature (e.g. Phares, 2006; Vetere, 2004). Singh (2003) notes that not only are fathers generally absent from the clinical setting and research studies, fathers are underrepresented in advertising campaigns for drug treatments for ADHD and support forums (online networks) for parents who have children who have ADHD. In this study fathers being observers in the process appeared to a mix of father's scepticism and related to work.

The reaction to the diagnosis was typically met with mixed emotions and a theme of guarded acceptance emerged in the current study. In this study some fathers expressed relief that their son had been diagnosed as it explained their son's behaviour and allowed them to seek help for their son (extract 12, 13, 63 and 64). Indeed feeling relieved once the diagnosis is made is consistent with previous findings from the Harborne *et al.* (2004) study. However, some fathers still felt particular difficulties ambivalence towards the diagnosis. Fathers "guarded acceptance" may be associated with their beliefs on the aetiology of ADHD. As discussed in the introduction (section

1.2.5) Chen *et al.* (2007) report that mothers are more likely to see ADHD as a biological condition, not related to psychological causes and that it is global and stable; whereas fathers are more likely interpret ADHD as being related to psychological factors, such as lack of effort (extract 15).

4.1.2 Working with the diagnosis

In the current study the theme of dilemma emerged in the decision to medicate their sons (extract 22 and 24). When considering medication fathers experienced emotional turmoil, consistent with previous qualitative literature (Taylor *et al.*, 2006). Emotional turmoil was exacerbated by the fear that they felt after researching on the internet for information and the sense that there was no other alternative. Additionally Taylor *et al.* (2006) found that parents move through a process of grieving. Similarly, fathers in this study described feelings of anger, depression, and accepting on some level that they had to medicate their son for their sons for their child's benefit – the “bigger picture” (extract 17 and 19).

The lack of choice that fathers felt is an important finding ethically and from a service provider perspective. Certainly the Scottish Intercollegiate Guidelines Network (SIGN, 2001) recommends that family based psychosocial interventions of a behavioural type (SIGN, 2001). Fathers were offered a six week family based behavioural intervention in a didactic group format. However, a didactic approach may increase resistance to acquiring skills (Cunningham *et al.*, 1993) and by devising their own solutions more shifts behaviour and attitudes can be seen (Meichenbaum & Turk, 1987). However, within the NHS resources to facilitate such an approach may not be sustainable due to the financial implications. Therefore the families often felt that medication is their only option; but as the study highlights medication is commonly associated with side-effects.

The “*ongoing dilemma of medication*” highlighted the problematic nature of medication. As discussed in the introduction (see section 1.1.2) side effects such as insomnia, decreased appetite irritability and mood lability are common (Barkley, 2006). This current study indicated that constant awareness and subsequent testing of medication and management was needed. The study highlights that for parents

witnessing side effects in their children is a difficult experience (extract 24) but that beneficial effects that medication are also seen, which in turn leads to a “juggling act” (extract 22). However, the psychological impact of medication may be that fathers feel that the locus of control over managing their son’s behaviour is an external one.

4.1.3 Perplexed parenting: parenting a son who has ADHD

Within the theme “*perplexed parenting*” the fathers’ narratives suggest a difficulty in adapting parenting approaches to manage ADHD. In the sub-theme “*shifting boundaries – what is ADHD and what is not?*” many fathers appeared to have poor confidence in differentiating between ADHD behaviour and ‘non-ADHD’ behaviour (extracts 26 and 27). This is consistent with previous qualitative research in parents of children who have ADHD (e.g. Kendall, 1998).

The attributions that the fathers made for their sons behaviour had effects on their management of their son, and often the attribution differed to the mothers. As discussed in the introduction (see section 1.2.5) attributional research suggests that the explanation that a parent gives the child’s behaviour (e.g., “he’s doing this on purpose”) has an impact on their disciplinary and emotional responses (Johnston & Freeman, 1997). In this study we see that when a father is removed from the behaviour that the emotional response is lessened and the child’s behaviour is interpreted taking into consideration the context of ADHD (extract 29). Indeed in the attributional styles of parents are recognised as an important treatment target in parent training programmes (Cunningham *et al.*, 1998). However, within the theme “*compromise as a result of medication*” some fathers’ narratives described frustration towards their sons despite knowing that the reason for the behaviour is unintentional (extracts 30 and 31). Perhaps this suggests that emotions can not always be overridden by reappraising the attribution for the behaviour, especially sleep patterns and routine within the house are disrupted and fathers’ resources are depleted (such as when tired).

The sub-theme “*fathers’ active (frustrated) parenting*” suggests that all fathers’ narratives highlight a difficulty in maintaining a positive approach to parenting when

the child's behaviour invokes emotional reactions. Indeed this is consistent with literature that suggests parents of children who have ADHD often show a less positive and more controlling approach to child management (Keown & Woodward, 2002). In this study, positive attempts are described to manage behaviour such as appropriate ignoring strategies that that appears to have been a joint decision between both parents (extracts 35 & 36). Yet the emotional reaction to the son's behaviour impacts on consistently implementing strategies.

The finding that fathers feel frustrated in their parenting may be related to their feelings of responsibility for their son's behaviour. Johnston and Freeman (1997) found that in comparison to mothers, fathers took more responsibility for their children's behaviour including oppositional behaviour, ADHD symptoms and prosocial behaviour. Indeed in this study, frustration often appeared to be linked to non-compliance.

These findings emphasise the importance of targeting fathers for interventions such as behavioural training, as inconsistencies in parental management, parenting stress, coercive parenting are associated with and harsh negative approaches in parenting lead to poorer long term adjustment (Barkley, 2006).

A theme of "*powerless parenting*" emerged from most of the fathers narratives, although was evident at varying levels and was strongest for P07. This sense of powerless may be linked to low self-efficacy (Bandura, 1977) as a strong sense of self efficacy is built through mastery of experiences. The fathers described their various attempts to manage their son's behaviour yet their son's unmanageable behaviour continued to undermine their parenting. Indeed throughout the narratives fathers felt lost in their parenting approach; however, for P07 this was most evident. This can perhaps be linked to his son's oppositional behaviour. Previous literature has suggested that in parents who have children with oppositional defiant disorder the parent-child interaction can be characterised as "tit for tat" (Barkley, 2006) this consistent with the process that emerged in P07 narrative (extract 34). Indeed low levels of parenting competence (linked to self-efficacy) have shown in parents who have children with higher levels of oppositional behaviour (Johnston, 1996) which would be consistent with P07 account. This is an important finding, as discussed in

the introduction, low parenting efficacy in fathers is linked to poorer child outcomes (Hoza *et al.*, 2000).

4.1.4 The battle to balance family life

The emergence of balancing family life reflected the impact that having a son had on the family system and every father's battle to regain a balance. Indeed the imbalance in the family as a result of ADHD has implications from a systemic perspective. As discussed in the introduction (see section 1.2.3) family systems theory (Minuchin, 1985) suggests that the interactions between the people within the sub-systems in the family are regulated by patterns that are recurrent or stable. However, as the fathers described the patterns within the household were not stable as a result of their son's behaviour. Fathers hoped and tried to treat their son as 'normal' in order to maintain the equilibrium, which is consistent with Kendall's (1998) qualitative study where parents in the early stages of diagnosis believed that normalisation was possible as long as they worked hard (this is also reflected in extract 24). However, for most fathers the main battle emerged as being a process of feeling lost in managing conflict resolution between the children and guilt related to the impact on children. According to Barkley (2006) when such imbalance exists changes in the structure of the family would need to improve to manage this and parent training (PT) can address this. Indeed Chronis *et al.* (2003) argue that it is important to treat the whole family and not just the child with ADHD.

The sub-theme "*maintaining a balance with mothers*" also emerged. Throughout the course of the diagnosis and treatment of differing opinions between parents emerged. "Battles with partners" have been reported in qualitative literature focussing on mothers, which related to feeling unsupported by fathers and feeling that fathers were dismissive of their concerns (Harborne *et al.*, 2004). In the current study (as discussed in the sub-theme "*the search for answers*") some mothers and fathers opinions differed regarding their son's problems in the initial stages, which is perhaps a reflection of some fathers seeing the behaviour as that of a 'typical' boy. In the current study differing opinions continued through diagnosis and subsequent management of their son. Arguments often centred on the mother's belief that behaviour was related to ADHD and father's belief that the behaviour was intentional.

This is consistent with previous research investigating the attributions and beliefs for the child's behaviour between mothers and fathers of children of ADHD (Chen *et al.*, 2007). As discussed in the introduction (see section 1.2.5) Chen and colleagues found that mothers were more likely to attribute behaviour to an internal cause related to the medical model of ADHD whereas fathers attributed behaviour to being intentional.

Johnston and Mash (2001) report that having a child who has ADHD and in particular having a child who has ADHD and co-morbid oppositional defiant disorder is related to marital dissatisfaction. In the current study a theme of marital dissatisfaction did not emerge. Fathers made a distinction between marital disagreement at the beginning of the diagnosis and the medication decision, and through time and adjustment to management this dissipated, no one reported been dissatisfied in their relationship. This is a possible result of the study methodology as two parent families were specifically recruited. Different findings may emerge where participants are separated or divorced parents. This is an important finding as Arnold *et al.* (1997) found that spousal love was associated with more effective discipline and lower levels of love was associated with more laxness and over reactivity.

This study found that for all fathers there was a move toward joint parenting. Perhaps the move toward joint parenting may be related to conserving the relationship with the mothers. Singh (2003) suggests that in order to preserve their relationship with their wives, fathers may hide their scepticism of the diagnosis and medication from the mother following observing the benefits of medicalisation on the mothers. Nevertheless, the parents had begun a process of shifting attitudes and working in a more joint manner as parents, and according to Cunningham (2006) a successful outcome of parent training relates to shifts in expectations and beliefs towards child behaviour and discipline.

4.1.5 Heightened sense of parenting responsibility

In the current study a theme of "*trying to protect son's future*" emerged. All fathers described a fear related to their son becoming involved in crime later in life as a result of their diagnosis. Certainly as discussed in the introduction (see section 1.1) ADHD is related to developing substance use problems and serious conduct problems. In

response to this fear, all fathers appeared to be proactive and pre-emptive in order to try and stop their son from trajectory developing. All fathers described actively encouraging their sons to take part in hobbies (extract 54) which for most fathers often involved a financial investment. However, often fathers described the difficulties when their sons lost interest and dropped out of hobbies or had difficulties taking part (extract 27) which was described as leading to frustration for fathers'. This process of continually trying to encourage sons to take part in hobbies but sons' losing interest is perhaps similar to the 'wearing out' process described by Kendall (1998). Kendall (1998) describes parents of children who have ADHD going through a circular pattern of "...getting stuck, giving up, recharging, burning out, and getting stuck again" (p. 846).

Some fathers described attending school meetings to "*defend their sons*" (e.g. extract 55) which is consistent with the study by Harborne *et al.* (2004) where a theme of 'battles with teachers' emerged. Harborne *et al.* (2004) described mothers battling with teachers regarding the diagnosis and battled that allowances should be made for their son's behaviour. Additionally Taylor *et al.* (2006) qualitative study also found a similar theme of "*educating others*" whereby parents proactively educated those who came into contact with their child about the nature of their child's disability. Certainly this was consistent with some father's reports, perhaps suggesting that mothers and fathers feel similar responsibilities towards their sons in the context of school. Interestingly, this study highlights that within the school context fathers' appear more accepting of the ADHD diagnosis and defend their sons in the context of a medical condition as P01 highlights (extract 29) yet personally struggle to accept the diagnosis (extract 3).

In a similar vein, in the sub-theme "*defending son's character*" this highlights the heightened protective nature of fathers which extends from social situations to the interview itself. Previous studies such as the qualitative study by Taylor *et al.* (2006) have highlighted that parents find it frustrating that their parenting practices are publicly questioned by those who do not know their child. However, "*defending son's character*" in the interview emerged in most of the narratives, which is a theme that has not emerged in previous studies. Perhaps it is an extension of the fathers continued difficulty in accepting that their son is a 'problem' (as discussed in the sub-

theme “*guarded acceptance*”) therefore, discussing their son as a problem is difficult. Or perhaps it is a reflection of the fathers’ tendency to normalise their son’s behaviour (see the sub-theme the “*search for answers*”). Interestingly, in most interviews, the fathers made a distinction between their son’s behaviour and being physically violent. That is most fathers discussed their son’s aggressive behaviour but then defended their son’s character and noted that their son was not physically violent. This perhaps reflects the fathers’ heightened awareness of the judgemental attitude in society toward aggressive behaviour in children.

“*Fathers absorbing responsibility*” was a theme that emerged across all the transcripts. Fathers described their son’s poor responsibility for their son actions as a result of the condition and the fathers’ attempts to try and protect their sons from harm. This theme is similar to a theme of ‘transferring responsibility’ seen in the qualitative study by Kendall’s (1998). Kendall (1998) described the parent’s paradigmatic shift from the goals of normalisation to “salvaging what was left” (p.848) such as accepting that their child may not finish high school. Kendall (1998) reports that parents then came to the conclusion that:

...they could not help their children succeed if it did not come from within the children, that they had to step back and let children take responsibility for their actions, consequences... (pp. 848)

Kendall (1998) reported that transferring responsibility ended when the child moved out of the house. However, in the current study, most fathers, did not appear to have reached the stage of transferring responsibility described by Kendall (1998). This is perhaps a reflection of the older sample of children in Kendall’s (1998) study, which included children up to the age of 18, with a mean age of 11 in the sample. In the current study there was a tone of cautious optimism in some narratives that their sons would develop responsibility in the *future* and fathers could then transfer responsibility (extract 60). This current study perhaps highlights the difficulty for older parents of children who have ADHD in ‘transferring responsibility’ (extract 61) as P07 described that he will probably be deceased by the time his son leaves high school, therefore perhaps there is less time for the transfer of responsibility in comparison to other fathers’. His age, in addition to oppositional behaviour and socio-

economic circumstances (extract 62) meant that he had a more negative view for the future and for P07 responsibility and protecting his son was very salient.

4.1.6 Managing uncomfortable emotions

The narratives suggest that most of the fathers use cognitive strategies as a means of managing uncomfortable emotions. All but one participant (P07) appeared to use a strategy of comparing themselves to those who are worse off in order to reappraise their situation in a more positive light. Indeed downward comparisons have been seen in health psychology; Wood *et al.* (1985) report that in breast cancer patients, comparisons such as focussing on a positive aspect of a lumpectomy, by comparing oneself to those who have lost a breast. However, downward social comparisons have not been discussed in the qualitative literature relating to adjusting to the ADHD diagnosis. This is an interesting finding, as discussed some fathers had difficulties accepting the diagnosis yet use a form of cognitive reappraisal to adjust. Certainly readjustment of expectations and beliefs is focus of parent training interventions (Robin, 2006) therefore fathers already appear to be using reappraisal to adjust to the diagnosis. However, as discussed in “*fathers’ active (frustrated) parenting*” perhaps for some fathers an ongoing cognitive reappraisal of their son’s behaviour and discipline is more difficult to implement.

Many fathers’ also used another cognitive strategy of “*moving on*” where they did not focus on the negatives and the past and focussed on the future. This related to immediately after disciplining their sons (extract 73 and 74) and related to core feelings related to diagnosis and medication (extract 72 and 75). This was an interesting finding in that fathers’ appeared to avoid difficult thoughts and feelings, which has not been reported in qualitative research of mothers. Of course mothers in these studies may well have used these strategies; however, it may not have been a strong enough theme to report.

4.2 Implications

4.2.1 Fathers’ silence

The finding that fathers throughout the course of the process from pre-diagnosis to the current day fathers' described emotional difficulties such as guilt, powerlessness and difficulties accepting their son's diagnosis and behaviour is an important finding. As demonstrated in the current research the silence of fathers at the clinic means that fathers' concerns, worries and opinions may not be being heard and therefore not being addressed. In addition, this study found that fathers were often a psychological step behind the children's mothers in terms of accepting that there was something wrong (see section 3.1.1) This has implications for fathers' adjustment, emotional well-being, the family system and possibly their subsequent parenting of their son in the context of ADHD.

4.2.2 Perplexed parenting

The study found that the fathers' acceptance of ADHD appeared to be guarded. Fathers appeared to have difficulties accepting and adjusting to ADHD and appeared to hold a different attributional style to the mother. In the initial stages through to the time of the interview, the attributions that the fathers made relating to their son's condition and behaviour, appeared to cause difficulties. In particular, the attributions for the behaviour often appeared to be seen as intentional, rather than a result of a medical condition. Certainly fathers appeared to struggle to differentiate between behaviour that was related to ADHD and behaviour that was not (section 3.3.1). As discussed, the attributions that fathers made often had an impact on the emotional reaction of the father and appeared to lead to frustration and anger. The differing attributions also appeared to lead to disagreements between the parents.

4.2.3 Fathers' feeling powerless

The finding that fathers often appeared to feel powerless to their situation and their son's behaviour was an important finding. From the diagnosis stage fathers were powerless in the diagnostic process; recommendations included in section 4.3 may help to redress this balance. During the medication decision fathers appeared powerless, as they appeared to have no other choice but to accept medication through their son's behaviour. As discussed this often appeared to be linked to emotional turmoil for the fathers. Indeed, the fathers appeared to feel that they had tried

everything that they knew to manage their son's behaviour, yet the behaviour continued or in some cases got worse. As discussed this may have an impact on fathers' self efficacy or having to medicate their son's to manage their behaviour may lead fathers' to feel they have an external locus of control over their son's behaviour. This is an important finding, as discussed in the introduction, low parenting efficacy in fathers is linked to poorer child outcomes (Hoza *et al*, 2000).

The study also highlighted specific difficulties for particular fathers. For one father (P07) the impact of having a son who presented with oppositional behaviour appeared to be particularly linked to powerlessness. As discussed there is a link between lower levels of parenting competency in parents of children who have higher levels of oppositional behaviour (Johnston, 1996). Therefore this may have implications for the father's emotional well-being as well as his parenting.

4.2.4 Fathers' responsibility

The finding that the family system appeared to be affected by the son who had ADHD is important. Fathers battled to balance family life, such as their other children and their spouses. As discussed, the fathers appeared to battle to spread the care and attention for their other children with the son who had ADHD. Fathers also had to mediate conflict between the siblings. In addition the fathers appeared to feel a heightened sense of parenting responsibility. The time and energy to deal with all these factors may link to a burden of stress on the couple and family functioning (Podolski & Nigg, 2001) and perhaps poorer coping (Keown & Woodward, 2002).

4.3 Recommendations

The findings of this study lead to the recommendation for clinical practice that clinicians be mindful of the fathers when the family are invited to participate in the assessment. This supports the view of Hecker (1991) who suggests that clinicians should speak directly to the father and state the importance of all family members attending. Hecker (1991) also suggests that in cases where fathers are reluctant to attend (perhaps in the current study those fathers who initially normalised their son's behaviour) clinicians can intervene. As Phares *et al*. (2006) suggest it is important to

highlight to fathers their importance in the family and the rationale for including them in the treatment.

Of course, as highlighted in this study, fathers are frequently the principle breadwinners of the family and therefore unable to attend appointments. Certainly offering flexible appointments may offer one solution to engaging fathers in the treatment. Within the National Health Service, this may not always be possible, although there is an ongoing drive by the present government to engage patients in services through offering increased choice about access to treatment (DOH, 2006).

Including fathers in the initial stages of the assessment is important, as can be seen from this study fathers did not feel part of the process and instead often relied on second hand information from mothers. For some fathers this appeared to be linked to difficulties adjusting. In the initial stages clinicians should be careful to explain the process of assessment and take care to ask fathers their opinions when they attend. Where fathers' can not attend or are perhaps a stage behind mothers in terms of acknowledging the difficulties, an information pack could increase the fathers understanding of the assessment process and increase a feeling of involvement and empowerment.

However, the fathers' reluctance to accept a medical model should be acknowledged, indeed this study has highlighted that for many fathers, pathologising their sons and seeing their son's as having a 'condition' or a 'disorder' was not a positive experience. This calls into question the usefulness of a diagnosis and medical treatment for some families. Certainly the fathers are not alone in the scepticism of ADHD as a medical construct, as discussed in the introduction (1.1.1). Perhaps families would prefer a systemic approach rather than a disorder based paradigm for their children. Perhaps the use of behavioural-psychosocial treatments as a first level approach (Conners *et al.*, 2001) would be useful in fostering positive family function. Certainly, the *Incredible Years* programme (Webster-Stratton & Handcock, 1998) has an evidence base in improving parenting competencies and in reducing disruptive behaviour (Webster-Stratton, 1990).

Indeed, providing more options for parents is recommended. The service, from which the participants were recruited, following diagnosis, offered a six session family based intervention. Some fathers attended this group, although it was unclear how many and how many sessions the fathers attended. Nevertheless, fathers reported feeling that they had to accept medication for their son's behaviour. The BPS document, "*attention deficit hyperactivity disorder: guidelines for successful multi-agency working*" (2000) report that medication should be used as part of a multi-modal intervention, which may include educational, behavioural and other psychological approaches. The BPS document also reports that these interventions should be applied prior to the prescription of medication. Certainly giving fathers more options and behavioural training following diagnosis could reduce feelings of powerlessness and increase parenting self efficacy and thus improve parenting practices.

The findings of this study highlight that ADHD impacts on the family balance ("*the battle to balance family life*"). Therefore the study supports the view that there is great benefit in services treating not only the child but the family system to work toward strengthening overall family functioning. This is in line with current recommendations (e.g. SIGN, 2001) that a multimodal approach of medication and psychological interventions targeted to the families care is used. Perhaps the implementation of a well established, researched parent training programme, such as that described by Barkley (1997) or for parents of adolescents, the community parent education program (COPE) described by Cunningham (1998). This may target the shifts in the family system and allow fathers' to learn more parenting techniques to manage these.

Of course, as established in this study fathers are less likely than mothers to attend the clinic, and it has been discussed in the literature that fathers are less likely to be involved in child-related therapy (Phares *et al.*, 2006) therefore this highlights the need for services to think creatively about how to get fathers involved.

The finding that P07 had particular difficulties in terms of his son's oppositional behaviour suggests that services should be aware of the particular types of ADHD behaviour and the impact on parents. Perhaps services could offer more regular

appointments for these families and more intensive family interventions with these parents and children.

4.4 Methodological Critique

4.4.1 Limitations

The current study used interviews as means of accessing fathers' experiences. Therefore the accounts were retrospective in nature and relied on the father's memory of events and perhaps events may have been forgotten. Also as time has progressed, a reconciliation of thoughts and feelings may have occurred, therefore the emotional processes that might have been important at that time may be less accessible and not fully addressed.

All the participants were recruited from the clinic at which their sons were receiving treatment. It is possible that this may have influenced the information that the fathers disclosed. However, efforts were made to ensure that participants understood and were reassured that the interview would not impact on the care of their son and the fathers appeared surprisingly open when discussing their experiences. The service was dedicated to the assessment and treatment of ADHD and fathers did not express dissatisfaction with the service. However, had the fathers been recruited from other departments different experiences may have been reported.

The interview was only carried out at one particular point in time. Perhaps P07's recollections and descriptions of his experience may have been different had there not been a worsening of his son's behaviour in the weeks preceding the interview. It would be of interest to conduct longitudinal research to determine how parent's experience changes over time in terms of adjustment to their child's difficulties.

Finally, the present findings are limited to the fairly homogenous participants in the study and are therefore not generalisable. It included two parent families, son's who were taking psychotropic medication, and did not include daughters. This was by design, however, it is important to be cautious when considering the

recommendations for clinical practice as the recommendations may not be relevant to those outside of the group studied.

4.4.2 Strengths

The study carried out was a rigorous in-depth analysis of fathers' experiences of having a son who has ADHD using IPA methodology. This was an area in which there was a dearth of knowledge and the study serves to highlight fathers' perspectives in addition to the qualitative research already existing on mothers' experiences. The study uncovered and unpacked a series of important experiences, meanings and feelings that fathers go through when managing a son with ADHD. This has covered diverse issues raised by their experience of a diagnosis of ADHD, the management of difficult behaviours, their impact on both their relationship with their son and the rest of the family unit, and the feelings enmeshed in all these processes. The study has highlighted a number of clinical implications for the ADHD service and ideas for future research.

4.4.3 Future Research

Future research could investigate the fathers' perceptions of having a daughter who has ADHD as a comparison to the current study. The current study only included sons who were taking psychostimulant medication. Perhaps qualitative investigations could focus on a group of children who are not taking medication. Future studies could also investigate the link between fathers who normalise their son's behaviour in the initial stages and do not perceive their son to have difficulties that merit investigation and their subsequent adjustment to the diagnosis.

4.5 Researcher Personal Reflections

4.5.1 Reflexive Diary

In line with qualitative research good practice guidelines (see section 2.7.3 for discussion on reflexive diary) I kept a reflective diary throughout the process. This details my thoughts and feelings during the research process. The most salient topics on which I reflected are described below.

4.5.1.1 Journey of Discovery

Whilst keeping the diary I became aware of perceptions and judgements that I held personally and professionally. During recruitment I began to worry about whether participants would opt-into the study:

Extract 77 31/3/8

I haven't heard from any participants yet, I'm starting to get worried. I'm starting wonder if studying fathers was a bad idea. Maybe the reason that there is so little research on fathers is because of work etc they don't have time to come to the clinic. I'm worried that they don't have much to say maybe if the mothers deal with the care of their son.

After carrying out some interviews I began to reflect on my original preconceived ideas about fathers:

Extract 78 15/06/08

I hadn't thought about it before the research but I think I may have held a bias about fathers seeing the study as a 'mother's role'. In fact I was humbled by the fathers attending and sharing their stories. Their struggles, their descriptions of their experiences, and the overwhelming want to protect their sons and their family is something that I feel privileged to hear. I feel a bit guilty about my preconceived ideas of fathers beforehand. And in fact, nearly half the fathers opted into the study.

This highlighted to me the unconscious assumptions that we all hold that are part of societal attitudes and how my own bias as a female might influence analysis. During the study I also reflected on my bias in how I think of ADHD as a biological condition or otherwise:

Extract 79 11/06/08

Before the research I had my doubts about ADHD as a diagnosis. I had carried out ADHD assessments in my placement and the results were not conclusive. I wanted a clear cut 'yes' without a doubt this is definitely ADHD, or no they definitely don't. But the whole ADHD paradigm seems to be like that. Full of confusion and grey areas. Just like the fathers find it difficult to differentiate between bad behaviour and ADHD, I too struggle with the concept of ADHD. But since carrying out the research and hearing the father's stories about their son's behaviour and their constant struggle to help their son, I think I have come to terms with the concept of ADHD. I do believe now that ADHD exists.

As a researcher, I had become aware of my judgements on ADHD, and sharply realised that I had to be at all times mindful of my 'other' role as a clinician, and my prior knowledge of ADHD. I tried to distance myself from my scepticism of ADHD as a concept and *listen* to the father's stories without judgement.

The role of researcher was difficult balance with my role as a clinician; with one father in particular the roles became blurred:

Extract 80: 16/05/08; interview with P07

This interview felt really different to the other fathers. The impact that his sons problems have had on him and his family's life made me feel really sorry for him. I just wanted to reach out and do something to help. He was older and looked physically tired – he said his body was starting to fail. Services don't seem to be able to help him and medication isn't working. I ran through the interview more than the other fathers, I just wanted to finish the interview and help him rather than asking him how he felt about it.

This highlighted to me the difficulties in carrying out research with related to a clinical population, where ethically the judgement has to be made as to when to stop an interview. The material he was discussing was sensitive and heart wrenching and his experience made for an interesting material and comparison to the other fathers. However, the interview was shorter than the others for ethical reasons. During the debriefing I offered P07 support in terms of local counselling services and advised him to consult his general practitioner should he feel the need. I also gained verbal his consent to consult with the head clinician of the ADHD service to check that he had an appointment for a review (see confidentiality section 2.5.3).

The power imbalance that automatically existed by carrying out research in a clinical setting and my role as a clinician may be something that has influenced the data:

Extract 81 15/04/08

I was transcribing P02 interview today and I began to reflect on his comment "I've tried to be as open as I can be but hopefully I came across ok". I'm worried that the fathers feel guarded and worried about what they are saying. Maybe it's because the research is in the clinical setting where their sons are being treated.

As I have not carried out a qualitative study before throughout the research I found myself anxious about whether I was carrying out the methodology in the 'right' way.

Extract 82 09/04/08

I've got my first interview today. I'm feeling quite nervous, I hope it goes ok. I hope that he has enough to talk about and I hope that I can listen to the experience without worrying about what to say next.

Extract 83 09/04/08

I've just finished the first interview, it went really well, he had loads to talk about and already I can see big themes that are relevant for him, he seemed to talk a lot about his difficulties with his son taking medication. I'm still not sure if I'm doing the interviewing 'right' I really didn't say much I just let him talk.

The first two interviews were used as pilots to practice my interview technique. Interviewing was a skill that I think I developed throughout the process of the research.

Extract 84 18/06/08

I'm finding it really hard to think about superordinate themes because everything is so interrelated. I'm finding the analysis really confusing and I have so many themes that I'm feeling lost. I really want to make sure I do justice to the fathers' experience. I've read plenty of IPA 'guidelines' but I can't help but worry that I'm not doing it 'right'.

Extract 85 14/07/08

I'm feeling a lot better about how to structure my themes now. I was speaking to my supervisor and I think my problem was that I was trying to look at the similarities and 'fit' everyone into a structure. My supervisor reminded me not to forget it's an ideographic approach and look at the differences, the exceptions, as well as the similarities.

Analysing the data was something that I felt anxious about throughout the process; however, by comparing and discussing my coding to my supervisor's I think that helped me feel more confident about the analysis.

Overall I believe the reflexive diary helped me to notice my bias and to be aware of this throughout the research process. I also feel that the whole process has been a learning experience, a 'journey of discovery'.

4.6 Conclusion

The present study has generated knowledge about fathers' experiences of having a son who has ADHD. Such knowledge had added to the qualitative literature on mothers of children who have ADHD. The study also provided further knowledge about the experience of adjustment for fathers' once the diagnosis has been made.

The qualitative methodology has yielded rich and in-depth information about the experiences, meanings and feelings that fathers go through when dealing and

managing a son's ADHD, which would not have been accessible using quantitative methodology.

The study found that the journey of diagnosis followed the trail made by the son's mother and for most fathers the journey was difficult, complex, and fraught with mixed emotions. Once the diagnosis was made fathers had to "work with the condition". However, fathers continued to describe feeling perplexed, frustrated and lost in their parental management. The stability of the family equilibrium became unbalanced through ADHD and fathers' battled to maintain a family balance. Fathers' also fought to make positive changes for their child by being pre-emptive, proactive and by having a heightened sense of protection for their sons.

Obtaining the fathers' perspectives has been valuable in terms of making the service more aware of the fathers' needs. It is hoped that the breaking of the fathers' silence will allow recommendations to be implemented to allow a smoother adjustment to the management of the condition.

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APPENDICES

Appendix I

DSM-IV-TR Criteria for ADHD (APA, 2000)

I. Either A or B:

- A. Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:**

Inattention

1. Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has trouble keeping attention on tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has trouble organising activities.
6. Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
7. Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
8. Is often easily distracted.
9. Is often forgetful in daily activities.

- B. Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:**

Hyperactivity

1. Often fidgets with hands or feet or squirms in seat.
2. Often gets up from seat when remaining in seat is expected.
3. Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
4. Often has trouble playing or enjoying leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".
6. Often talks excessively.

Impulsivity

1. Often blurts out answers before questions have been finished.
 2. Often has trouble waiting one's turn.
 3. Often interrupts or intrudes on others (e.g., butts into conversations or games).
- II. Some symptoms that cause impairment were present before age 7 years.
- III. Some impairment from the symptoms is present in two or more settings (e.g. at school/work and at home).
- IV. There must be clear evidence of significant impairment in social, school, or work functioning.

- V. The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Based on these criteria, three types of ADHD are identified:

1. ADHD, *Combined Type*: if both criteria 1A and 1B are met for the past 6 months
2. ADHD, *Predominantly Inattentive Type*: if criterion 1A is met but criterion 1B is not met for the past six months
3. ADHD, *Predominantly Hyperactive-Impulsive Type*: if Criterion 1B is met but Criterion 1A is not met for the past six months.

Appendix II

Inclusion/ exclusion criteria

Inclusion criteria:

- Fathers of males who have ADHD, who lived with the child's mother at time of diagnosis and currently;
- The child has a diagnosis of ADHD who is receiving treatment (either pharmacological or psychosocial, or both);
- The child with ADHD is male;
- The child is aged between 8 and 11.

Exclusion criteria:

- Lack of fluency in English;
- Child currently being assessed for ADHD.

Appendix III

Socio-cultural Background of Participants

P01

P01 was a 44 year old male employed full time (council worker) who had been married to his wife (34) for 13 years (and described being happy in his marriage). His wife worked part time. He did not seek the diagnosis himself. He had two other children, another son (15) and a daughter (5). His son (11) had been diagnosed with ADHD age five (and had no other comorbid conditions). His son was receiving psychostimulant medication for his condition. His medication had been changed due to side effects. His son received extra support at school.

P02

P02 was a 44 year old male, employed full time (who was a manger in the construction industry). He had been married to his wife (44) for 16 years. He did not seek the diagnosis himself. His wife worked part time. He had two other children, another son (6) and a daughter (14). His son (9) had been diagnosed with ADHD age six. His son was receiving psychostimulant medication. His medication had been changed due to side effects. His son received extra support at school.

P03

P03 was a 39 year old male employed full time (who worked in the catering industry) who had been married to his wife (37) for 15 years. He did not seek the diagnosis himself. His wife worked part time. He had another son (12) who had been diagnosed with Aspergers Syndrome. His son (8) had been diagnosed with ADHD age six. His son was receiving psychostimulant medication. His son's medication had been changed due to side effects. He was out of the country at the time of the diagnosis. His son received extra support at school.

P04

P04 was a 36 year old male who is employed full time (was a supervisor in a factory). He was the only father in the study to seek the diagnosis himself. He had been married to his wife (35) for 16 years. His wife worked full time as well (in a school). He had

one child, a daughter (14). His son (10) had been diagnosed age eight. He was receiving psychostimulant medication which he described not having any side effects. His son received extra support at school.

P05

P05 was a 40 year old male employed full time (who worked for the civil service). He did not seek the diagnosis himself. He had been married to his wife (39) for 18 years. His wife worked part time. He had two other children; two daughters aged 16 and 13. His son (9) had been diagnosed with ADHD aged six. His son was receiving psychostimulant medication. His son's medication had been changed due to side effects. His son received extra support at school.

P06

P06 was a 45 year old male who was unemployed at the time of the interview (but had previously worked as a tiler). He did not seek the diagnosis himself. He (was not married and) had been with his partner (42) for 13 years. He had no other children. His son (10) had been diagnosed with ADHD when he was aged seven. His son was receiving psychostimulant medication. His son's medication had been changed due to side effects. His son received extra support at school.

P07

P07 was a 60 year old man employed full time (who worked in the building trade). He had been married to his wife (54) for two years. He did not seek the diagnosis himself. His partner did not work. This was his second marriage. He had daughters (from his previous) from his first marriage, aged 30 and 38. His son (11) had been diagnosed with ADHD age nine. His son was receiving psychostimulant medication which had been changed due to side effects. His son received extra support at school. He described feeling unsupported by services.

P08

P08 was a 39 year old man who worked full time (was self employed). He (was not married and) had been with his partner (45) for 20 years. He did not seek the diagnosis himself. His partner worked part time. He had three other children, two

daughters (5), and another son (9). His son (11) had been diagnosed with ADHD age seven. His son was receiving psychostimulant medication. His son's medication had been changed due to side effects.

Appendix IV



The Child and Adolescent
Mental Health Service



I am writing to give you details of a research project that is being carried out in The Child and Adolescent Mental Health Service which you may consider taking part in.

You are being invited to take part as your son attends ' [redacted] '. Taking part in the research is entirely voluntary and will not affect the care of your son.

If you have any questions, please contact Leigh Lynch on the department number.

Many thanks



Appendix V



The Child and Adolescent
Mental Health Service

Invitation to participate in a study

I am writing to tell you about a research project that I am running in the child and adolescent mental health service, which I hope that you might consider taking part in.

I am interested in finding out how fathers think and feel about the experience of having a son who has attention deficit hyperactivity disorder (ADHD).

Please find enclosed an information pack which tells you more about what this study is about and what it would involve for you. If you would like to take part in the study please sign the consent form and post it in the stamped addressed envelope. I will then phone you to arrange an appointment to meet. This meeting should take no longer than 60 minutes.

If you have any questions please contact me on [redacted] or email me at [redacted]

Participating in this study is entirely voluntary and you can withdraw at any time without having to give a reason. If you did agree to participate any information you give me will remain private and confidential. Your participation in this research project will in no way affect your child's care at CAMHS.

Thank you very much for your time.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'Leigh Lynch'.

Leigh Lynch
Trainee Clinical Psychologist



Appendix VI



PARTICIPANT INFORMATION LEAFLET



Fathers' experiences of having a son who has attention deficit hyperactivity disorder

We would like to invite you to take part in a research study that is being conducted by Leigh Lynch, in part fulfilment of a Doctorate in Clinical Psychology at the University of Edinburgh.

Before you decide you need to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask Leigh if there is anything that is not clear or if you would like more information.

- Part 1 tells you the purpose of the study and what will happen if you decide to take part.
- Part 2 gives you more detailed information about the conduct of the study.

PART 1

What is the study about?

From research we know more about mothers' experiences of parenting a child with ADHD than we do about what it is like for fathers. There is little research into fathers' views or perspectives on ADHD. Leigh would like to find out about fathers' experiences of having a child with ADHD so that the whole family is taken into account when planning treatment interventions for children with ADHD.

Why have I been invited to take part?

You have been asked to take part because your son has been diagnosed with ADHD.

Do I have to take part?

No. It is up to you to decide. You are free to withdraw at any time, without giving a reason. This will not affect the care you or your child receives.

What will I be asked to do?

1. If you decide that you would like to take part in this study please complete the attached 'opt-in slip'. Send this off in the pre-paid envelope included in this information pack.
2. When Leigh receives your opt-in slip, she will contact you by telephone to arrange a suitable time to meet with you and answer any questions you have.
3. The meeting will be a one-to-one interview with Leigh. The length of the meeting will depend on how much information you wish to share, but should last no longer than 60 minutes. You can stop at any time for a break.

The meeting will take place at . The kinds of questions that you might be asked are "What is your experience of having a child with ADHD" and "Has this experience affected the relationships within the family?" Travel expenses will not be reimbursed.

4. The meeting will be audio taped for analysis. This recording will be completely anonymous and will contain no identifying information.
5. Afterwards Leigh will listen to the tapes of the conversations and write a report of what people have said.
6. If you agree, Leigh might ask you to meet her again for ½ hour to ask you to look at the report of what you have said. This is to check that Leigh has reported what you have said accurately. Alternatively, if it is more convenient, Leigh could send you a copy of the report and telephone you to discuss if what Leigh has reported is accurate.
7. Once that's finished Leigh will send you a sheet telling you what she found from the conversations with the people who helped.

What are the possible benefits of taking part?

The study is not intended to be of direct benefit to yourself and your child. However, we hope that what we will enable us to develop our service to help all families who have a child with ADHD.

What happens if I no longer want to take part in the study?

That's fine. Just contact Leigh and let her know. Unless you specify otherwise, any information already collected via the interviews will be used. The standard of care your son receives will not be affected if you withdraw from the study.

THANK YOU FOR READING SO FAR! IF YOU ARE STILL INTERESTED, PLEASE LOOK AT PART 2

PART 2

What will happen to the information collected in the study?

All the information you give will be treated as confidential. Information from interviews will have names and other identifying information taken from them before using any quotes or other information in reports or other publications. This data will be kept in a secure place and destroyed after 10 years. Interview tapes will be kept in a secure place and destroyed as soon as they are written down. The only time we would tell anyone else what you have told us is if we are worried about your safety or the safety of someone else.

Did anyone else check the study is OK to do?

Yes, the Research Ethics Committee, which has responsibility for scrutinising proposals for medical research on humans, has examined this proposal and has raised no objections from the point of view of medical ethics.

Who else can I speak to if I have concerns?

We do not anticipate there will be any problems. Should there be any problems please contact Leigh and she will do her best to help you. If you need to make a formal complaint you can contact any of the following people. Head of Service for Child and Adolescent Mental Health, Dr Eleanor Sutton, Clinical Psychologist, Clinical and Health Psychology, University of Edinburgh, Patient Relations Officer,

What if I have a question about the study?

You can contact Leigh on [redacted] or by email at [redacted] or at The Child and Adolescent Mental Health Service, [redacted]

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET

Appendix VII



Fathers' experiences of having a son who has attention deficit hyperactivity disorder

I have read the participation information leaflet and agree to Leigh Lynch, Trainee Clinical Psychologist, contacting me to discuss taking part in the research study.

My contact details are:

Name:

Address:

Telephone number:

OK to leave message on telephone answer machine (please tick box):

Yes

No

☐☐

Appendix VIII



CONSENT FORM



Fathers' experiences of having a son who has attention deficit hyperactivity disorder

Researcher: Leigh Lynch

Please initial box

1. I confirm that I have read and understand the information sheet dated ____/____/____ (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my (or my child's) medical care or legal rights being affected. ☐
3. I understand that anonymous information from the interview collected during the study may be looked at by responsible individuals from The University of Edinburgh, from regulatory authorities or from the NHS trust, where it is relevant to this research ☐
4. I understand that interviews will be tape recorded solely for the purposes of the research study as described in the participant information sheet (____/____/____, version 2) ☐
5. After the interviews have been transcribed, and all identifying factors have been removed I understand the researcher may use quotes from my interview in subsequent reports and publications. ☐
6. I consent to being contacted in the future to be given information about any follow-up studies. ☐
7. I agree to take part in the above study. ☐

Signature.....Date.....

Name of participant (block capitals).....

Telephone contact.....(Home).....(Work)

Signature of person taking consent Date.....

Name of person taking consent in block capitals.....

Thank you for your help

Appendix IX

Research Ethics Service

Research Ethics Committee Research Ethics Office

Miss Leigh Anne Lynch, Trainee Clinical Psychologist

Date:
Your Ref:
Our Ref:
Enquiries to:
Extension:
Direct Line:
Email:

25 February 2008

Dear Miss Lynch

Full title of study: **Fathers' experiences of having a son who has attention deficit hyperactivity disorder**
REC reference number: **08/S0501/3**

Thank you for your letter of 12 February 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		21 November 2007
Investigator CV		09 November 2007
Protocol	1	27 November 2007
Covering Letter		27 November 2007
Interview Schedules/Topic Guides	1	27 November 2007
Letter of invitation to participant	1	27 November 2007
Participant Information Sheet	2	12 February 2008
Participant Consent Form	1	27 November 2007

Document	Version	Date
Response to Request for Further Information		12 February 2008
Letter from College of Humanities and Social Science		09 November 2007
Clinical Trial Liability Insurance		20 April 2007
Letter of Invitation from Lead Clinician	1	12 February 2008
Opt-In Slip	1	06 February 2008
Original Signatures: Ms E Sutton		27 November 2007
Original Signature: Ms M Bucukoglu		28 November 2007
Liability & Professional Indemnity Insurances		20 July 2007
Recruitment Flier	1	28 November 2007
Supervisor's CV Dr Eleanor Sutton		09 November 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from <http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

- Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
- Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

08/S0501/3

Please quote this number on all correspondence

Yours sincerely

Chair

REC

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	08/S0501/3	Issue number:	0	Date of issue:	25 February 2008
Chief Investigator:	Miss Leigh Anne Lynch				
Full title of study:	Fathers' experiences of having a son who has attention deficit hyperactivity disorder				
<p>This study was given a favourable ethical opinion by REC on 21 February 2008. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.</p>					
<i>Principal Investigator</i>	<i>Post</i>	<i>Research site</i>	<i>Site assessor</i>	<i>Date of favourable opinion for this site</i>	<i>Notes ⁽¹⁾</i>
Miss Leigh Anne Lynch	Trainee Clinical Psychologist	NHS	REC	25/02/2008	

Approved by the Chair on behalf of the REC:

..... (delete as applicable) :.. (Signature of Chair/Co-ordinator)

..... (Name)

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.



Appendix X

Miss Leigh Anne Lynch

Date: 14 April 2008

Your Ref:

Our Ref:

Enquiries to:

Direct Line:

Fax:

Email:

Dear Miss Lynch

Following approval from the Research Ethics Committee on 25 February 2008 I am pleased to confirm that I formally gave Management approval to "Fathers' experiences of having a son who has attention deficit hyperactivity disorder" on 14 March 2008.

The Research Governance Framework for Health and Community Care applies to all research undertaken within NHS. The Framework sets out standards and details the key responsibilities of key individuals, including the research sponsor, principle investigator, other researchers and supervisors of students undertaking research.

All those involved in the project will be required to work within accepted guidelines of research governance and IHC-GCP guidelines.

A copy of the Framework and links to background annex material can be accessed via the Chief Scientist Office website at <http://www.show.scot.nhs.uk/cso/ResGov/ResGov.htm> and ICH-GEP guidelines may be found at <http://www.ich.org/pdf/ICH/eb.pdf>

You will be required to provide a progress report on your project at the end of the study. We will also require a copy of the final report, when available. You will also be asked annually to complete a form on the activity taking place in relation to the study within for each financial year during which it is active here. The appropriate forms will be provided to you by the Research and Development office when they are needed.

Yours sincerely

Chairman
Chief Executive

NHS Board is the common name of

Health Board

Appendix XI

Interview format:

- Introductions and chat
- Outline of interview format (check if participant has any questions)
- Consent form (ethical issues – confidentiality etc)
- Demographic information
- Interview

Interview introduction:

“I’ve asked you to come along today to take part in an unstructured interview. This means that although I have a some topics I am interested in, I hope the interview is more of a chat, a one sided chat with me saying very little, most of my questions will follow on from what you’ve said. If I ask you a question that doesn’t make sense then please ask me. Sometimes in these interviews people worry that they are talking too much, don’t worry about that if you go off track I will ask you some questions to set you right again. Because I want to find out about your experience, your experience of having a son who has ADHD, there are no right or wrong answers, I’m interested in your experience. Some of my questions might seem stupid or obvious questions, but it’s really because I’m not taking anything for granted and I want to find out your opinions. Please feel free to be as open as possible as I’d like to try and find out what this experience is really like for you. The interview usually lasts about an hour but it can be more or less, it depends on how much time you wish to spend”

Background information of researcher:

“I’d like to tell you a bit about myself, I have no children myself and so no experience of being a parent. I’m a trainee clinical psychologist, although I have some experience of working in this department, I won’t automatically know what your experience of assessment and treatment was like. Also, the project is being carried out as an academic study, and although I will feed the results back to the head of service, I don’t have any direct clinical input so it won’t directly influence [son’s name] treatment. If you have any questions about your son’s treatment I would suggest you contact [clinician]”

- Check if participant has any questions

- Begin interview:

What was your experience of your son being diagnosed with ADHD?

Prompts

- What did you think and feel (about your son's problems, the diagnosis and treatment)
- How did your experience compare to that of your wife/ partner's experience?
- How did the experience affect your relationship?

How does having a son with ADHD affect your daily life?

Prompts

How does it affect:

- Life at home
- Relationships
- Emotionally
- Practically
- Work

After the interview

Debrief:

- How was the interview?
- How did you feel doing it?
- Was there anything that you were wondering about? Any questions?
- Anything that I could do to make you more comfortable?
- Explanation of what happens next.
- Check if participant wants the results summary.

Appendix XII

Transcription notation

The following features of talk were transcribed. This is an adapted selection of notation conventions from Antaki, Billig, Edwards, Potter (2003) as cited in Coelho (2005)

- Omitted text: (...) an ellipsis is used to indicate the omission of ten or less words from the narrative from the original transcript. It is also used to either shorten the excerpt or to indicate the removal less relevant material. It is also used to indicate the start and end of excerpts where the speaker is mid narrative.
- Omitted text: [lines suppressed] is used to indicate where more than ten words omitted.
- Pauses: (..) two dots will signal a two second pause in the narratives.
- Intonation: (,?!) are used as they are in current text to indicate the speakers intonation.
 - ? indicates a raising inflection
 - ! indicates an animated tone
 - . indicates a natural pause
 - , indicates a breathing “comma-like” pause
- Emphasis: underscoring indicates some form of stress (either by volume or pitch) given to a word or fragment.
- Loud: capitals indicate louder sounds in contrast to the rest.
- Descriptions of behaviour or non-speech sounds: (()) when describing sound that add but are not part of “proper” speech double parenthesis are used ((laughs))
- Identifying features and additional information: [] identifiable information such as names and places will be substituted by a description within square brackets. Square brackets are also used where it is deemed necessary to clarify a term or the subject of an ambiguous sentence.
- To remain true to the data, the participants’ use of regional dialect has been respected.

Appendix XIII

Key: Emerged in participant's narrative

Did not emerge in participant's narrative

Themes: Participant 01

3.1 Themes	Example from transcript	line number
3.2.1 The search for answers 3.2.1.1 Fathers' awareness that something is not 'right' 3.2.1.2 Fathers' following the journey that had already begun 3.2.1.3 Observing the diagnosis: fathers' removed involvement 3.2.1.4 Fathers' guarded acceptance	<p>'he wasn't like other boys at that age' 'she went to the doctor with him first'</p> <p>'I came a couple of times. [wife] dealt with most of it'</p> <p>'I still struggle with the concept of ADHD, I still don't think I've come to terms with it'</p>	<p>18 115</p> <p>144</p> <p>272</p>
3.2.2 Working with the diagnosis 3.2.2.1 The first dilemma of medication 3.2.2.2 The ongoing dilemma of medication	<p>'That destroyed me that [son] had to take tablets' 'we'll maybe have to review the tablets again'</p>	<p>432 458</p>
3.2.3 Perplexed parenting – parenting a son who has ADHD 3.2.3.1 Shifting boundaries – what is ADHD and what is not? 3.2.3.2 Shifting boundaries – compromise as a result of medication 3.2.3.3 Fathers' active (powerless) parenting 3.2.3.4 Fathers' active (frustrated) parenting	<p>'it's a fine line...I still struggle with it is where the ADHD starts and the bad behaviour begins' 'you know its not his fault because of the medication'</p> <p>'uncontrollable really uncontrollable' 'its its constant with him'</p>	<p>54</p> <p>495</p> <p>28 19</p>

<p>3.2.4 The battle to balance family life</p> <p>3.2.4.1 Striving to keep a balance with the other kids</p> <p>3.2.4.2 Maintaining a balance with mothers</p>	<p>‘You [son] cannae stay home with your brother ‘cause you fight’</p>	<p>323</p>
<p>3.2.5 Heightened sense of parenting responsibility</p> <p>3.2.5.1 Trying to protect son’s future</p> <p>3.2.5.2 Defending son’s character</p> <p>3.2.5.3 Fathers’ absorbing son’s responsibility</p> <p>3.2.6. Superordinate theme: managing uncomfortable emotions</p> <p>3.2.6.1 Comparison</p> <p>3.2.6.2 Moving on</p>	<p>‘I went no way, I said I’m sticking up for him’</p> <p>‘a really really loving boy, he is...really really loyal’</p> <p>‘he doesn’t see danger, where you would see danger’</p> <p>‘There’s a lot of people in a lot worse places than I am’</p> <p>‘you’ve got to get on with it’</p>	<p>599</p> <p>385</p> <p>80</p> <p>299</p> <p>148</p>

Appendix XIV

<p>Reaction to diagnosis – not surprised – Why? Expected? Awareness of difference in comparison to siblings. Wife more aware.</p> <p>Wife instigated diagnosis “pushed” adamant – different opinions? <u>Both</u> attended meetings – communication – school. “Form of ADHD”. Medication. <u>We</u> looked into medicine.</p> <p>Scepticism – at first – changed opinion over time. Especially in comparison to other children – sees a difference in their behaviour.</p> <p>Perception of son’s behaviour “inappropriate”. Societal norms. Social situations – “ridiculous” –</p>	<p>I: the first thing that I wanted to ask you about was, what was your experience of your son being diagnosed with ADHD</p> <p>P05: hmmm.. I was .. a bit taken aback at first, but not surprised, because he has two older sisters and we eh did notice a difference in his behaviour compared to them, more my wife rather than myself</p> <p>I: what do you mean more your wife?</p> <p>P05: well it was her that you know pushed for eh some form of diagnosis eh she was adamant there was <u>different</u> about his behaviour eh when when we attended meetings at the school and then started coming to [child dept] and diagnosed that he did have eh a form of ADHD and em we looked into, medication, and em, we’ve just been living with it since then</p> <p>I: what was your thoughts on the sort of problems that you might have been having?</p> <p>P05: em .. I think I was a bit more sceptical at first but then as he has grown you can see, especially when he’s mixing with other kids, that there is a difference in how [son] behaves, em</p> <p>I: can you tell me a wee bit more about that?</p> <p>P05: just eh .. sometimes his behaviour can be inappropriate you know he can make em try and to eh get him to behave you know if your out for a meal or something for</p>	<p>Reaction to diagnosis not surprised – aware. Wife more aware of son’s problem.</p> <p>Wife’s push – adamant.</p> <p>Differing opinions?</p> <p>Joint effort.</p> <p>Medication.</p> <p>Scepticism initially.</p> <p>Acceptance of difference – awareness that something ‘not right’.</p> <p>Father’s perception of behaviour.</p>
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embarrassed? Son seen as immature in comparison to others. Defensive/ protective of son – “not physically violent”. Son’s emotional difficulties. Father having difficulties expressing sons problems – how does he manage sons behaviour?	example with family he can start making ridiculous noises and .. behave in like someone .. quite a bit younger than he is .. em .. he also can have.. violent outbursts, I don’t mean physically violent, I just mean em that the outbursts themselves you know he’s his eh .. his language .. what’s the word I’m looking for ... em .. you know he’ll lose his temper quite easily you know shouting and he can become very emotional I: Right, can you tell me a wee bit more about that? P05: well em, when he when he loses his temper, its sorta .. builds and builds and builds and builds and then all of a sudden he’s he’ll burst into tears you know em then he wants a cuddle and maybe my wife will get him to go for a shower or something like that to calm down em but he’s never he’s never physically violent with anyone, and it all depends what situation he’s in, when he was <u>first</u> diagnosed, I thought, that sometimes em .. don’t know if it’s the right way to put it but sometimes I felt that he was wanting a rise, especially with my wife I: what do you mean? P05: taking advantage em I mean I could get very frustrated with his behaviour, eh, whereas my wife was a lot more understanding, and until I looked into it, ADHD, and I fond out <u>why</u> he behaves in this way, what’s causing it, and eh .. and then he went on the Ritalin for the first time and it made a massive difference to his to his behaviour, eh but eh	Son’s behaviour embarrassing? Defensive / protective. Impact of son’s behaviour. Son’s behaviour uncontrollable. Perplexed at son’s behaviour – wife dealing with son’s behaviour. Defensive / protective. Perception changed over time? Perception of behaviour as intentional – attributions of behaviour. Frustrated father. Wife – different perception of behaviour – different stage of acceptance? Wife not seeing behaviour as intentional.
Pressure – emotional intensity. Difficulty understanding behaviour? Wife dealing with son’s behaviour. Never physically violent – protective. Initial thoughts on intentional behaviour leading to frustration. Wife different [perception – different understanding? Knowledge led to understanding? Benefits of medication, <u>but</u> , side effects – dilemma.		

<p>Had to take son off medication due to side effects.</p> <p>Medication helped behaviour.</p> <p>Attributions for son's behaviour – intentional.</p> <p>Accepting that son is “different” to siblings.</p> <p>Adjustment to “alien” situation.</p> <p>Frustrated.</p> <p>Embarrassed.</p> <p>Adapting to condition.</p> <p>Education allowing an understanding.</p> <p>Inconvenience – son's condition impacting on daily life – stress?</p>	<p>.. but it really affected his appetite, he started to lose weight quite a bit, eh his sleep was really terrible so we had tae take him off that, he's now on a mixture of Ritalin and em what's the other one? Is it stratera or something, well he's on a he's on two eh tablets a day now and these they really do make quite a difference to his behaviour</p> <p>I: the medication side of things is something I would like to talk about and ask you a bit more about, but I wonder can we go back to em you know your kinda thoughts on the behaviour at first that you had started to describe there?</p> <p>P05: well like at first I thought eh he was taking advantage of my wife eh trying to get away with things .. you know with the way he behaved you know you just I was thinking, the situation is we had had two girls and we never had any problems with their behaviour, whereas [son] is obviously different, so you go from one situation that you are used to, to this situation which is totally different, totally alien to you, so like I say I was a bit more frustrated in the way he behaved you know he would make you .. not angry but you know sometimes you could you felt it could be a bit embarrassing, again, that was <u>until</u> I looked into the ADHD and got a bit educated about it .. em but since then you know I've started to understand like I say I started to understand why he does things eh what's causing it you know and how the medication affects him, that kinda thing, he also has a problem with eh, bedwetting, em and he still does, I had to get up this morning and had to strip his bed and</p>	<p>Medication dilemma.</p> <p>Attributions (intentional)</p> <p>Awareness something 'not right'</p> <p>Frustrated father.</p> <p>Adjustment.</p> <p>Accepting that there is a cause for behaviour.</p> <p>Impact of son's condition.</p>
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<p>Comparison to siblings – son different.</p> <p>Frustrated and annoyed at son's developmentally inappropriate behaviour. Reappraisal – "not his fault" – adjusting to the diagnosis.</p>	<p>get it into the machine, and at first I found it like I say my daughters are quite eh quickly out of that stage whereas [son] is now, he'll be 9 in [month] you know, I was actually quite annoyed about that, but again you know you get yourself educated and look into it and realise that its not his fault, <u>I think</u> that's the big thing, you <u>have</u> to realise that its not his fault, there's other.. things eh at work here not just eh you know its no just eh his fault there are other factors...</p> <p>I: can you tell me maybe a wee bit more about that, about sort of the understanding of it, once you felt you were a bit more educated</p> <p>P05: well I really don't have any examples of it, I've got patience I realise I need to allow [son] .. em .. maybe some more leeway because he has this condition, and sometimes his behaviour will <u>not</u> be appropriate to where you are or what you're doing, but that doesn't stop him being chastised, because obviously we don't allow the fact that he has ADHD to <u>excuse</u> behaviour that that's not eh acceptable em so I suppose really I don't know if punishment is the right word but when you're trying to eh to explain things to him sometimes <u>that</u> can become quite frustrating because there's no, especially like I say when he when he like when goes into these eh when he loses eh <u>not</u> loses control but when he loses his temper you know trying to reason with him is <u>just</u> you know it's a non starter really, so you really have to let him calm down and put him in his room and the</p>	<p>Emotional impact of son's condition as a result of attributions. Adjusting to son's condition. Acceptance.</p> <p>Adjusting to condition. ADHD explaining behaviour. Working with the condition.</p> <p>Trying to discipline son, but ADHD complicates this. Actively trying to explain. Frustration at son's behaviour.</p> <p>Powerless to son's behaviour – self efficacy.</p>
<p>Diagnosis resulting in a shift in expectations and management.</p> <p>More tolerance but still has to discipline son.</p> <p>Trying to discipline son and trying his best to explain, but, is frustrated.</p> <p>Difficulty exemplifying son's behaviour despite knowledge of son's condition – still feels frustrated.</p> <p>Resignation – can't reason with son. Adapting to behaviour – "let him</p>		

<p>calm down" – but still frustrated.</p> <p>Actively trying to explain & parent.</p> <p>Doubts whether behaviour intentional or not.</p> <p>Behaviour disruptive in social situations.</p> <p>Awareness – always trying to watch for behaviour – ever present responsibility.</p>	<p>next thing you hear the crashing and the banging, eh that kinda, ken that can be quite frustrating, <u>but</u> eh as I say once you learn about his condition you realise that this can happen em and let him calm down and <u>then</u> try and explain what you can, because, but I mean other other times he's, it's almost like he likes the <u>attention</u> you know if again to use the example if your out having a meal with family or something and you know some of the times he does, you feel he does something to to eh attract attention and cause fuss .. em so really you know you're trying to watch for that kinda thing.. because obviously that's not, you're no gonna get away with that, whereas other times eh, its because of his condition, so I think that's that's something that I've hud tae I've hud tae learn eh to watch for in a situation where he's .. where he's at it basically and other times when he's when he's got a problem ..so that's .. it</p> <p>I: that's interesting, I was wondering a wee bit about what was the experience of the actual diagnosis, you know how did it come about, and</p> <p>P05: .. eh .. right, my wife was <u>adamant</u> there was something wrong with his behaviour, <u>she</u> has an aunt who has a daughter with, not ADHD, autism, eh who is very sceptical about about the authorities, education, because of her experiences, and she said to my wife that if she felt there was something wrong with [son] that she would she should pursue it to the enth degree, so my wife set about doing that, going to the doctor, eh, but basically I think</p>	<p>Frustrating.</p> <p>Dichotomy – behaviour, frustration, understands that it's ADHD, but, thinks it's intentional.</p> <p>Differentiating between ADHD and 'non' ADHD behaviour.</p> <p>Ever present responsibility.</p> <p>What's ADHD and what's not – learn. Balance.</p> <p>Wife's adamant / strong belief that there was a problem.</p> <p>Wife initiating journey to diagnosis – fathers then following behind.</p>
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<p>Father not sure of the clinician's name – less involved?</p> <p>“It was then decided” – situation out with fathers control?</p> <p>School sceptical - reflecting father's initial thoughts – perhaps reinforcing his initial confusion or scepticism?</p> <p>Son's variable behaviour – difficulties of diagnosis? Confusing?</p>	<p>the first point of contact was the GP who then referred us here, eh we both attended the meeting with Dr, I cant remember his name, I think he went off ill, then we saw the gentleman that he sees at the moment, so em it was then decided that he would be monitored at school eh he was diagnosed with ADHD, the school, em I think they were em I think they were a bit more sceptical because they didn't see eh that he had much of a problem</p> <p>I: right can you tell me a bit about that?</p> <p>P05: well basically we went to meetings with the head teacher, deputy head and his classroom teacher who was quite happy with his progress em but he did have problems you know he would em things like 'b' and 'd' you know he couldn't differentiate between them you know eh not just 'b' and 'd' other letters 'p' and 'q' that kinda thing em .. so <u>she</u> said that there was, didnae see a problem with his behaviour you know his classroom behaviour wasn't that big a problem to them whereas when he came home you eh at some points his behaviour was eh so there seemed to be quite a difference there em</p>	<p>Father involved – but can not remember the name of the clinician.</p> <p>Father involved (in school meetings)</p> <p>Confusion?</p>
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Appendix XV

Table 1: master table of themes for all participants

Themes	Participants							
	P01	P02	P03	P04	P05	P06	P07	P08
3.2.1 Superordinate theme: the search for answers	✓	✓	✓	✓	✓	✓	✓	✓
3.2.1.1 Fathers' awareness that something is not 'right'	✓	✓	✓	✓	✓		✓	✓
3.2.1.2 Fathers' following the journey that had already begun	✓	✓	✓		✓	✓	✓	✓
3.2.1.3 Observing the diagnosis: fathers' removed involvement	✓	✓	✓		✓	✓	✓	✓
3.2.1.4 Fathers' guarded acceptance	✓	✓	✓		✓		✓	✓
3.2.2 Superordinate theme: working with the diagnosis	✓	✓	✓	✓	✓	✓	✓	✓
3.2.2.1 The first dilemma of medication	✓	✓	✓	✓	✓	✓	✓	✓
3.2.2.2 The ongoing dilemma of medication	✓	✓	✓		✓	✓	✓	✓
3.2.3 Superordinate theme: perplexed parenting – parenting a son who has ADHD	✓	✓	✓	✓	✓	✓	✓	✓
3.2.3.1 Shifting boundaries – what is ADHD and what is not?	✓	✓	✓		✓		✓	
3.2.3.2 Shifting boundaries – compromise as a result of medication	✓		✓		✓	✓	✓	✓
3.2.3.3 Fathers' active (powerless) parenting	✓	✓	✓		✓	✓	✓	✓
3.2.3.4 Fathers' active (frustrated) parenting	✓	✓	✓	✓	✓	✓	✓	✓
3.2.4 Superordinate theme: the battle to balance family life	✓	✓	✓	✓	✓	✓	✓	✓
3.2.4.1 Striving to keep a balance with the other kids	✓	✓	✓	✓	✓	✓		✓
3.2.4.2 Maintaining a balance with mothers		✓	✓	✓	✓	✓	✓	✓
3.2.5 Superordinate theme: heightened sense of parenting responsibility	✓	✓	✓	✓	✓	✓	✓	✓
3.2.5.1 Trying to protect son's future	✓	✓	✓	✓	✓	✓	✓	✓
3.2.5.2 Defending son's character	✓	✓	✓	✓	✓	✓		✓
3.2.5.3 Fathers' absorbing son's responsibility	✓	✓	✓	✓	✓	✓	✓	✓
3.2.6 Superordinate theme: managing uncomfortable emotions	✓	✓	✓	✓	✓	✓	✓	✓
3.2.6.1 Comparison	✓	✓	✓	✓	✓	✓		✓
3.2.6.2 Moving on	✓	✓	✓	✓	✓	✓	✓	✓

Appendix XVI

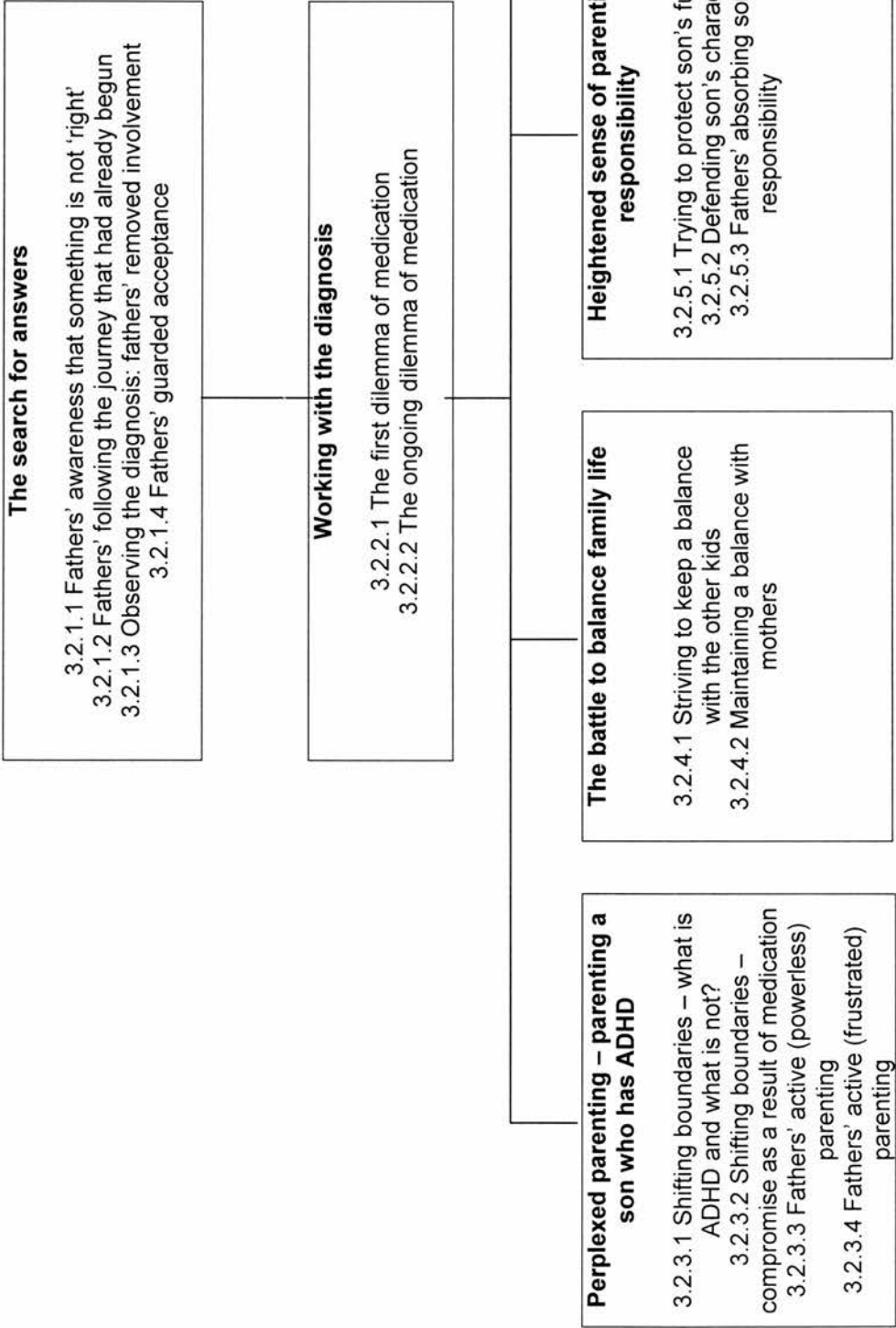


Figure 2. Identified superordinate and sub-themes

Appendix XVII



The Child and Adolescent
Mental Health Service

Dear ,

Re: Fathers' experiences of having a son who has attention deficit hyperactivity disorder.

I am writing to thank you for taking the time to take part in the above study. Your participation was very much appreciated. Sharing your story has allowed me to attempt to capture your experience of having a son who has ADHD.

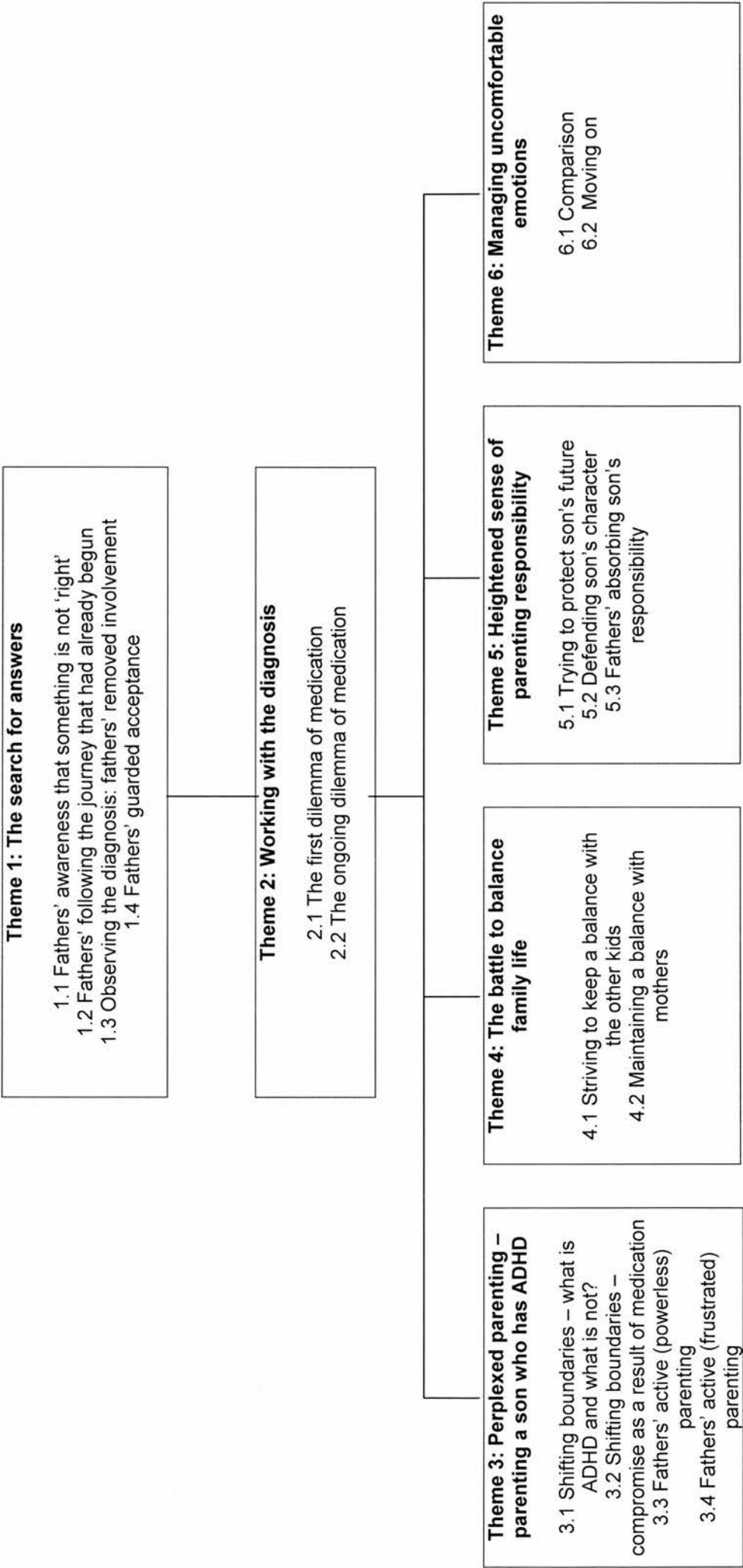
I have attached a summary of what I found for you to read. I would, however, be interested in comments that you feel you would like to make. Please feel free to phone the department if you feel that any description in the summary is inaccurate or if you have any other general comments.

Again, thank you very much for agreeing to take part in the study, your help is very much appreciated.

Yours sincerely

Leigh Lynch

The following diagram outlines the main themes and sub-themes found in the study.



Theme 1: the search for answers

Throughout all narratives a main theme “*the search for answers*” emerged. However, for all fathers, with the exception of P04¹, the journey to diagnosis was not initiated by them. This was a journey that follows the trail made by the son’s mother². This journey was difficult, complex, and fraught with mixed emotions. For all fathers the arrival at diagnosis was only the start of the journey which continues with ongoing mixed emotions and thoughts.

Sub theme 1.1: Fathers’ awareness that something is not ‘right’

In their retrospective accounts, most fathers described varying levels of early awareness that their sons appeared to be ‘different’ or ‘problematic’. Most fathers were confused and had attempted to explain this.

Some fathers questioned their competence as a parent; this is illustrated by P03 in the excerpt below:

P03: I was trying to show him what to do, how to behave and that like but he was not picking it up. An’ I’m going is it my parenting skills here or not? Because I spent a lot of my childhood in children’s homes. So I didn’t have actually have much of an actually close family upbringing, myself. An am going, what am I doing wrong here? Cause it’s got to be me if he’s no behaving and he’s no learning to behave properly.

Other fathers had attributed their son’s difficulties to behaviours within the normal range:

Interviewer: So you came along, and the diagnosis came about and you heard the term ADHD – what was your first thought?

P01: I thought it was a lot of rubbish to be honest, I thought it was absolute tosh, I could use stronger language than that but ...

Interviewer: You can if you want!

P01: I did, I thought it was all bullshit. I really did, I thought it was all fucking rubbish. I said “[Son’s] just being a typical boy” Still got that in my head. Even now at times I still go “take his tablets away”.

¹ The fathers’ identity is protected by using a personal identification number in place of their names.

² The father’s spouses will be referred to as “the mother” throughout the document.

Sub theme 1.2: Fathers' following the journey that had already begun

For the most part, the mothers typically instigated the journey to diagnosis and fathers followed. Some fathers were reluctant passengers on the journey to diagnosis. There was a theme of scepticism in contrast to the mothers' "adamance" that something was different about their son:

P08: She was kinda adamant for 3 or 4 years but, I mean I'm no saying I was in denial of the fact of him, ah dunno if it's a man thing or no but eh with him being our first born I was thinking there cannae be anything wrong with him because he's my son y'know I was kinda in denial in a way...

The above excerpt typifies the difficulty for some fathers to accept that their son had a 'problem'. This also highlights the difficulties arising/ created by divided opinion between parents which is further discussed in "*maintaining a balance with mothers*".

Some fathers' were more willing passengers and open to the journey to diagnosis. In the excerpt below P06 describes openness to the possibility that his son may have a medical condition:

P06: ... until [mother] says to me "there's something wrong wi' him" then I started thinking you know all the things that have happened in the past. Oh aye, right enough, when he was doing this, and doing that, just stupid wee things, that I just, I didnae ignore it at the time when it was happening, I just didnae think anything of it.

P07 had difficulties in terms of his son displaying aggressive behaviour. Therefore he was aware that his son's behaviour was out with the normal limits of childhood behaviour, and thus was open to the fact that his son may have a medical condition:

P07: ...for all these years we've had [son] facing up to me, fighting me, punching his mum, kicking his mum, actually knocking her down on the floor swearing, and we didn't know what was causing it, everything's going through your mind, your thinking brain tumours ...

Sub theme 1.3: Observing the diagnosis – fathers' removed involvement

Once the fathers followed the mothers on the journey to diagnosis, a theme of fathers being observers in the diagnostic process emerged in most of the narratives. For some fathers there was an expression of regret that they had not been heavily involved in the process. Some fathers were removed from the diagnostic process through personal circumstance, which meant they had little or no choice about their level of involvement and relied on second hand information from the mother. P03 was abroad for work whilst the diagnosis was made:

P03: I felt like I was lost out there, know what I mean? I was out there, there was nothing I could do, I could not alleviate the problem any, I could speak to him on the phone – that’s all I could do. It was frustrating... And it was it was just so frustrating, cause there was nothing I could do, I mean I just basically had to agree with her, I says “When I come back we’ll talk about it”.

In the excerpt we see the physical removal of P03 from the situation renders him powerlessness to the influence the situation. However, the theme of powerlessness and the mothers being the main agents of change typified most of the fathers’ experience, including fathers who attended the department. P05 did attend the clinic with the mother and describes this:

P05: I was more observing what was going on I think, eh my wife was more em, having an input, I was ok with that, cause it was her that spent most of the time with [son], I mean as I said to you, I mean I was working, I work a lot of hours, so she spent more time with him so obviously it more sense for her to speak to the doctor about it I mean I wanted to be here, I mean I wanted, I had questions I wanted to ask, I wanted to know what was going to happen, I went to the school meetings as well, for the same reason, I wanted to know what was going to happen with his education, what they were going to do about the situation.

Sub theme 1.4: Fathers’ guarded acceptance

The diagnosis of ADHD was met with intense and mixed emotions by all the fathers. All fathers described a fear of the diagnosis as the prognosis is linked to poor outcomes for some children such as crime (this is further discussed in *“heightened sense of parenting responsibility”*). The sub-theme of *“guarded acceptance”* emerged in most narratives. Acceptance was a complex process for most of the fathers, and was never a complete acceptance: they accepted that their son had a problem, and that the diagnosis allowed them to help their son; yet they struggled to fully assimilate the diagnosis.

Some fathers described the emotional impact of the diagnosis:

P07: ...I was devastated, coz I just I just wanted my wee boy to grow up as a normal wee boy and I had visions of all these tantrums, fights getting out of hand, getting into trouble ...

In the above excerpt we see the huge emotional impact of diagnosis and catastrophic vision of the future which typified the reaction to the diagnosis for many fathers. In contrast, some fathers expressed relief as the diagnosis explained their son's behaviour and felt more empowered to manage it:

P06 ... it lets us look out for things, a lot easier it gave us the answers we were looking for basically ... when he described the diagnosis and that, and he was telling us about it all, and that, and we're going "Ahh, that's probably why he was like that" ...

Some fathers expressed relief that the diagnosis gave access to the support that they felt their son needed and allowed them to help their son:

P02: ...diagnosis wise when it did³ happen we weren't surprised by by that point because we always, because by then we knew there was a problem and it was a case of just getting starting to get help for [son]'s sake...

P02 ... with the diagnosis was made and it made a massive difference to him the fact that he started getting the help that he should have been getting, we still had to push the school, all the time, we had meetings regular meetings...

However, the complicated nature of acceptance is described below where P02 later describes his personal difficulties in accepting the diagnosis:

P02: ... when they said ADHD I mean ... [mother] immediately starts ... reading up on it, she was looking up websites ... and saying "Oh this is [son]" and he does this, and he does that. Whereas I was, like, .. gonnae read about this "I know, aye aye" "I will I will" and I never ever done it, eh to be honest, because its just, I've got my way of accepting things ... I was a bit taken a while to accept the fact that he did have it and eh it caused a few arguments in the house, cause [son] would do behaviour, [mother] would put it down as ADHD and I put it down as just being, a wee pain, if you put like, and just kinda just give a row for something, come on, "That's ADHD" "You need to learn" "You need to read up on that"...

Theme 2: working with the diagnosis

³ Underlining of words denotes an emphasis on the word.

Having a son diagnosed with ADHD meant that fathers had to “work with the condition”. For all fathers this involved the consideration of medication. However, this medication was a highly emotive subject for most fathers and a theme of dilemma emerged.

Sub theme 2.1: The first dilemma of medication

The sub-theme of “*the first dilemma of medication*” was present in the narratives of all participants. Across all narratives, fathers described the negative reports of medication in the media that left them feeling shocked and scared. For most fathers this left them in a dilemma, as P05 illustrates:

P05... there was stuff that we read on the internet when we looked into it, it was quite, some of that stuff is really quite frightening both myself and my wife were really concerned about that, but then once we spoke to the Doctor, he put things in a different perspective, I think you’ve got to realise, you’ve got to look at the bigger picture ...

For most fathers there was a forced shift in thinking where they had no option but to accept medication for various reasons, such as their sons’ struggle in their academic progress and the impact of their son’s behaviour on others. P07 felt he had no other alternative but to try medication:

P07: I’d heard so many horror stories about it, but it got so bad that we had to come back in and says we’re gonnae have tae try it, ‘cause he was getting so out of hand ...

Many fathers did not want their sons to be medicated, which had an effect on their own emotions. This was described in rich detail by P01:

P01: That destroyed me that [son] had to take tablets. Initially I thought it’d be for the rest of his life and it destroyed me. I couldn’t speak about it ... I felt absolutely awful. I felt that so much guilt that the wee fella was on this. It just destroyed me, it really did. It gutted me ... I could see the bigger picture and it’d help [son]. It’d probably help us as a family cause we wouldn’t constantly be on his back and wouldnae be shoutin’ at him. But it didn’t make me feel any better. I could see the big picture as well, but it’s the fact [son]’s havin’ to take these tablets for the rest of his life.

Sub theme 2.2: The ongoing dilemma of medication

However, side effects of medication were described by most fathers, and again they faced a dilemma. On the one hand the medication helped one problem, but, on the other, the side effects in another area of their son's functioning were seen. Balancing the benefits and side effects of medication was an ongoing, unresolved process. This dilemma is described by P06:

P06: ... the first medication schoolwork was brilliant, so I was kinda in a dilemma, I'm going well do we keep him on that medication for his schoolwork? And we've got to see him look sad? So I'd the choice of keeping him on that, and doing that, or else putting him on this other medication, that I felt was making him, making him I felt making him a better person. I'm saying if its going to affect his school work, it wasn't that I was saying that I don't care, but I'm going like, we will obviously just need to try and push him, and try and encourage him to, do a wee bit more at school.

Theme 3: perplexed parenting – parenting a son who has ADHD

All fathers described having been confused and perplexed as to why their son was behaving in a certain way, and the diagnosis was seen as giving them an explanation. Fathers then talked of having to adapt their parenting approaches to take ADHD into account. However, most fathers continued to describe feeling perplexed, frustrated and sometimes lost in their parental management.

Sub theme 3.1: Shifting boundaries – what is ADHD and what is not?

As ADHD is a behavioural condition, differentiating between which behaviour is out with the 'norm', and thus related to ADHD, and which behaviour is "normal" but limit testing, was an issue that across recurred across many narratives. This concept was discussed to varying degrees, but, for a many fathers it was a difficult adaptation.

P01... it's a fine line I find it a fine line it's I still struggle with it is where the ADHD starts and the bad behaviour begins, because every kid's going to have bad behaviour, every kid. But not every kid has ADHD and sometimes I find it hard to differentiate between the two and that's not failing on [son] obviously it's a failing in me ...

Across many transcripts this was a typical difficulty as exemplified by P02 below:

P02: ... tell him to do, ten lengths [swimming], breaststroke, after three lengths [son's] lost interest, one because of the ADHD, concentration will no go any further, two, because he doesnae like it so its getting the combination of the two, of what part is actually losing the concentration, and which parts actually playing on it, and just like having a carry on because he's got the got the capability of doing the training but he's not got the eh concentration to do it but he's also no got the interest to do it...

Sub theme 3.2: Shifting boundaries – compromise as a result of medication

Across many of the transcripts a theme of “*compromise as a result of medication*” emerged. Fathers described the difficulty in maintaining the boundaries and structure within the household as a result of medication side effects. Side effects such feeling hungry at night were described as interfering with the routine within the house which often resulted in frustration. Across many of the narratives fathers described their son's poor sleep, and in some cases insomnia. For many of the fathers this involved shifting sleeping arrangements such as sleeping in their parents' bed, or fathers sleeping poorly themselves when hearing their son wandering the house at night and worrying about their safety.

P03 describes how medication has interfered with his son's appetite:

P03...he'll want something to eat, and this can go on until about one, two in the morning sometimes.

I: So what impact does that have then? How does it impact on you?

P03: Crabbitness [irritable]. Will you just get to your bloody bed? You've had enough to eat. No you're not getting it anymore, or you'll get it, and it'll be right, this is your last for the night, and then he'll come back in another half an hour later wanting something else to eat or something else to drink. And we have to give in to a certain extent because he hardly eats during the day, he's so skinny.

This highlights again the dilemma of medication. Although it improves their son's functioning to some extent the side effects impact greatly of the structure and routine of the family.

Sub theme 3.3: Fathers' active (powerless) parenting

Across many transcripts a theme of actively trying their best to parent but feeling powerless to help their son's behaviour emerged.

P03: ... you've still got to install in him like, stop what you're doing, think about it, behave yourself. And he does to a certain extent, but then again, he'll do it for a wee while and then he might kick off again. Other times you can go away and he'll be nice as nine pence, not cause a bit of problem. And then it goes blows up, and you go, well what caused that? Sometimes there is something that has happened that has caused him to go off on a tangent. Sometimes it's just no apparent reason but he'll come out with something silly.

P03 describes his endeavours to instil discipline, yet the behaviour continues. P07 also describes the difficulties in parenting his son in the context of ADHD:

P07: ... how do you control him, how do you show him right from wrong, when you shout at him, he'll shout back, shout louder back, you know he's got to get the last word, if you ignore it he thinks he's won, he thinks this is the way it is, and if you don't ignore it, he'll sit and argue all night...

Sub theme 3.4: Fathers' active (frustrated) parenting

All fathers described the frustration they felt in parenting their son. Fathers' frustration was linked to constant disruptive or active behaviour and repeated attempts to try and "get through to" their son.

All fathers described frustration which was often a result of their son's inattentiveness and feeling that they could not communicate with their son. Frustration related to having to constantly prompt their sons in tasks. Homework was described in some narratives as a particular source of frustration and was described as a 'battle'. In the following excerpt P04 describes his frustration whilst assisting his son in completing his homework:

P04: ... when he went on the medication you could see that he was trying a wee bit harder and he would still kid you on that he couldn't do it and some of the homework should only take about half an hour and you would be there for about two hours, you would still get kind of annoyed, come on you're at it, this is just half an hours worth of work ... you could feel yourself starting to get onto him again ...

P04: ... you kind of felt that you had been a bad dad kind of thing because you're getting onto him all the time ...

Theme 4: the battle to balance family life

As we saw in “*perplexed parenting - parenting a son who has ADHD*”, fathers often expressed struggling to manage their son’s behaviour. However, this process does not occur in isolation. The majority of fathers had other children and wives or partners, all of whom are affected by the son’s behaviour to varying degrees. In a sense, the stability of the family equilibrium becomes unbalanced through ADHD. In the next section the fathers’ *battle* to maintain a family balance is described.

Sub theme 4.1: Striving to keep a balance with the other kids

Fathers often described a challenge in balancing care and attention for their sons with ADHD and their other children. They also describe striving to parent all the children “the same” and treat their sons as “normal”. However, difficulties arose for a number of reasons which will be discussed below.

The difficulty in balancing attention and care for his son who has ADHD and his other children was particularly well described by P08.

In the excerpt below we see him describing his initial intentions not to treat his son differently to his other children:

P08: ... I had said to myself after ... he had been diagnosed as having it that I, I was gonnae try my best no to make him different from the rest of the kids, or, no to try and do it in a sneaky way, but for to try and deal with him differently, but try and make him feel the same, cause I think eh, the, the thing for him is that he does just want to fit in and that he doesnae really want to be different from everybody else, but he cannae help the way that this eh disorder that he has makes him react ...

In the above excerpt we see P08 making a conscious decision to treat his son’s condition in a covert manner, in order to protect his son’s feelings. However, this characterises the problem for all fathers: ADHD can not be hidden from siblings, as the behaviour is visible to others and so does impact on the family unit.

The battle to maintain family equilibrium was played out in a number of complex ways. A common theme across some transcripts was the imbalance in the family due to conflict amongst siblings as P05 describes:

P05: ... they [daughters] know that he has the problem, em, I think sometimes they feel he gets favoured a bit, em which isn't true, like they are typical teenagers, the world's against them ... sometimes you have to remind them .. that .. [son] behaves differently from people and em they just sometimes they just they're not interested in that, that argument, they just couldn't care less about that ...

Sub theme 4.2: Maintaining a balance with mothers

Across most narratives a theme of *maintaining the balance with the mothers* emerged. From the initial stages of diagnosis through adapting to the diagnosis, fathers described working through disagreements related to their son. There was a sense of readjustment, compromise and a move toward joint parenting across the narratives.

Disagreement over their son's management was seen across some of the narratives. P02 describes this below:

Interviewer: If you weren't doing what right?

P02: You know if I didnae handle it correctly or if I blew off on one as I would put it, lose the temper, [son's] classed as ADHD, [partner] turn and say "That's no gonnae make any difference to him – you need to do it this way". Of course me being me, I'll take that as being like a insult, your telling me how to, then of course, a wee bit of an argument, I think this is probably just normal for, I mean now, it's, no nothing like that now, that was just in the early days ...

P02 makes a distinction between the "early days". This suggests that through time there was a progression towards a more balanced, joint approach to parenting. He states it is "probably normal". Indeed across the narratives this did emerge. The impact of the differing parenting styles in the "early days" was also described by P04:

P04: ... I felt I we just weren't getting anywhere, then [mother] was getting on at me because I was getting on at [son] for not doing stuff, "Will you leave him alone? He'll get round to it when he's ready" And it's like, no, you shouldn't have to ask him five or six times, and then I'm not saying we fell out, but it was, you felt, there was an atmosphere ... We didn't get to the point to where we didn't speak to each other for a week or anything like it, just you could feel yourself getting snappy because she felt I was treating him unfairly if you like because I was asking him to do stuff and he wasn't doing it ...

In the above excerpt P04 refers to how he felt frustrated and irritated that his son would not adhere to his continued requests to do a task. This again highlights the

sense of frustration highlighted in the theme “*fathers’ active (frustrated) parenting*”.

Theme 5: heightened sense of parenting responsibility

Throughout all the narratives a theme of *heightened parenting responsibility* emerged. This was played out in a number of ways during the narratives, and seemed to be based in underlying fears and concerns for their sons. It appeared that fathers battled to counteract the realisation of fears by being pre-emptive, proactive and by having a heightened sense of protection for their sons.

Sub theme 5.1: Trying to protect son’s future

Across all narratives fathers were fearful of the link between ADHD and future criminal activity as P08 describes:

P08: That’s one thing that I do make sure that he’s, that we say to him, if you’re no gonnae go to that [sports club] you need to find something else to do, cause the last thing we want him doing is hanging about the streets or hanging about the shops. Eh, or getting into bother or that, I mean no, cause, I mean, it’s proven wi him having the condition he’s got that he’s susceptible for eh, a criminal life or a drug life, it’s one of our big fears for him y’know and that’s one of things we try and keep him active about.

Here, there appears to be a proactive and pre-emptive stance as a defence against a hypothesised catastrophic future. This was typified across all the narratives, and highlights the huge anxiety that fathers fear. Pre-empting issues at an early stage as means of protecting their sons was a common experience described in all the transcripts, this also extended to the school as P01 describes:

P01: ... they [school] quickly labelled [son] a bad boy. He got labelled right away, didn’t want to know. Schoolwork was dreadful, reading a nightmare, wouldnae do homework ... at the beginning all we got was negative feedback. And we’re going, aye, he’s this, he’s been diagnosed with ADHD, aye he’s got problems but he’s no as bad as they’re thinking. This cannae be right ... I went no way, I said I’m sticking up for him and I went in and set up the meeting.

Sub theme 5.2: Defending son’s character

As described above the dissonance between the fathers' perceptions of who their son is and the sons' public character – which often ranged from being seen as 'mischievous', to a 'bad boy' – was an issue that fathers appeared sensitive to. However, in external situations fathers adopted a protective stance to guard against what they anticipate are other people's negative judgements of their children.

In the excerpt below P03 describes the complexity of protecting his son from other people's judgements when they are in public:

P03... [In the cinema] you could hear him [son] squeal, and, shout, and everything like that, and you'd see the occasional person turn round, going "Interrupting my film here!". Tough. You know? Go and see the manager if your no happy.

Interviewer: How does that make you feel?

P03: To be truthful, I'm no bothered about what anybody does, as long as my boy's happy, em, they can moan and they can shout they can do whatever they want ...

Sub-theme 5.3 Fathers' absorbing son's responsibility

Fathers heightened sense of responsibility also involves in a sense absorbing their son's responsibility for their own safety, as they have not yet developed self control or judgement of consequences. Throughout all the transcripts fathers highlighted the difficult balance of 'letting go' and transferring responsibility to their sons and protecting them. Constant vigilance and a ubiquitous sense of responsibility emerged across all transcripts.

P04: ... I feel you kind of hold him back because you just can't trust him to go and do something ... we've let him take the dog past the corner that we normally go to because he would probably would just go and wander away off ... he would just kind of want to do his own wee thing or maybe he would go and speak to some of his pals or worse still the concern is he goes away for a walk and then somebody comes along stops the car, speaks to him, and then he goes away in the car with him, you've still got that kind of, you can't trust him to take the right decision on that ...

Theme 6: managing uncomfortable emotions

As we have seen throughout the analysis, fathers describe a wide variety of emotions throughout the diagnostic process and beyond, ranging from anger, fear, frustration and irritability, to powerlessness, hopelessness and sadness. In this section the hypothesised psychological processes that fathers intentionally or unintentionally use to manage these emotions will be highlighted.

Sub theme 6.1: Comparison

For the majority of fathers, once the diagnosis was made they compared themselves to others who they perceived were worse off. Some fathers also reappraised the situation by comparing it to a hypothetical worse case scenario: "*it could have been worse*". This appeared to serve as an adjustment strategy that allowed them to look at the situation from another perspective and, in turn, reduce uncomfortable emotions.

For P06 this comparison began during the appointment where he learned of the diagnosis:

P06: ... in a way when I found out, on what level that [son] had it I was quite relieved, because it wasn't as serious as some other kids, that's what [clinician] was saying to us as well, you know he says "I'm no saying its no a problem, it is a problem" But, he says, but on he says on [son's] level he says, and he told us all the ways it affected him, and I went, uch well I can live wi that!

P06: ... we [mother and father] basically just spoke about it, we came out of here [child department], and, spoke about it and went, ((exhales breath)) "At the end of the day its no as bad as, what, what it could have been, at least we know now"...

Whilst at the parenting group a number of fathers compared their son's condition to other parents' descriptions of their children:

P02: ... listening to other parents they've got kids that are kicking doors and fighting with folk and aw this kinda stuff having real trouble with them and that, I mean [son's] nothing like that, so I have a tendency to look .. .how could you put it .. [son's] lower scale ADHD, whereas the concentration is the problem ...

P04: I think we manage quite well, at the workshop ['Parents Inc'] you hear some of the stories about kids ... there was one woman she says she cannae take him shopping cause he used to run away from her in the shop, and she would go to find him and he would be lying in one of the freezers. And [son's] no done anything as bad as that, he's done, various bits and pieces, but he's never done anything like that.

In the excerpt below P05 engages in the process of comparison, in this case he describes ADHD as not being as bad as another illness.

P05: I mean obviously these things can be treated, I mean there's people a lot worse off with their children than I am, I mean like kids with leukaemia or something like that, that would have been a disaster, but no no no ADHD ...

3.6.2 Moving on

A number of fathers described not focussing on negative aspects, 'getting on with it' and moving forward, as another possible mechanism for coping with uncomfortable feelings.

P01 ... if I thought about [son] having that [ADHD] all the time ... I'm not saying I wouldn't be able to function but I'd have a constant lump in my throat and I can't have that. I can't have, that just for my own well-being ... It's not all about me. You've got family, you've got work commitments, [mother's] got health issues, my older son's now got health issues, you can't let it control or dominate the whole family... We've just got on with it. Maybe that's a way of coping, I don't know. But we've never .. emotionally, no I cannae, I don't, it's no good. I probably got more emotional in here talking about it the day than I would in a long time. I've got a wee bit of a lump in my throat the now cause I'm thinking about [son] with his ADHD but you can't let it run over you, you know, you can't let it do that to you. There's a lot of people in a lot worse places than I am, a lot.

P08: ... once it's [disciplining son] done it's done and we try to just kinda draw the line and move forward from it so's that eh .. so we can remain positive about it as opposed to thinking back to all the negative. Eh...I dunno, it's the only way that we can deal with it and things, y'know it really is, it really is...

P05 ... I wouldn't make a mountain out of a molehill, you know you just, you just shrug your shoulders or you you you .. you give them a row .. you know you move on .. I don't dwell on any of these kinda things ...

The present study has generated knowledge about fathers' experiences of having a son who has ADHD. Such knowledge had added to the literature on mothers of children who have ADHD. The study found that the journey of diagnosis followed the trail made by the son's mother and for most fathers the journey was difficult, complex, and fraught with mixed emotions. Once the diagnosis was made fathers had to "work with the condition". However, fathers continued to describe feeling perplexed, frustrated in their parental management. The stability of the family equilibrium became unbalanced through ADHD and fathers' battled to maintain a family balance. Fathers' also fought to make positive changes for their child by

being pre-emptive, proactive and by having a heightened sense of protection for their sons.

Obtaining the fathers' perspectives has been valuable in terms of making the service more aware of the fathers' needs. It is hoped that these findings will allow recommendations to be implemented to allow a smooth adjustment to the management of the condition.